TESTIMONY

OF

JAN STEWART, CRNA, ARNP

ON BEHALF OF THE

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS

BEFORE THE

HOUSE JUDICIARY COMMITTEE

June 22, 1999

AMERICAN ASSOCIATION OF NURSE ANESTHETISTS
ANTITRUST TESTIMONY
HOUSE JUDICIARY COMMITTEE
June 22, 1999

Chairman Hyde, members of the Judiciary Committee, good morning. My name is Jan Stewart and I am a certified registered nurse anesthetist and President-elect of the American Association of Nurse Anesthetists ("AANA"). I am pleased to be testifying today regarding potential changes to the federal antitrust laws.

INTRODUCTION

The AANA is the professional association that represents over 27,000 certified registered nurse anesthetists ("CRNAs"), or 94 percent of the practicing nurse anesthetists in the United States. AANA appreciates the opportunity to provide our experience with respect to the need for vigorous enforcement of the antitrust laws.

As a leader in the advanced practice nursing community, we applaud your attention to the promotion of competition in the health care market place. However, AANA is extremely concerned about any weakening of the antitrust laws. We strongly believe that creating new antitrust exemptions for physicians could have severe unintended consequences and seriously undermine the larger goal of increasing competition in our health care system and providing affordable high quality care. Specifically, we believe that antitrust exemptions such as those currently being considered by the Committee would put nurse anesthetists at a serious and permanent competitive disadvantage with respect to contracting with health plans because it would :

1. Allow anesthesiologists to form cartels that discriminate against or exclude nurse anesthetists;
2. Sanction attempts by anesthesiologists to eliminate competition between themselves and nurse anesthetists using spurious claims regarding patient health and safety;
3. Drive up the cost of health care coverage for all Americans without any concomitant increase in the quality or availability of health care.

We believe that strong antitrust laws and robust enforcement are crucial to protect competition and consumer choice in the health care system.

Part I of our testimony will provide important background about CRNAs and put their current antitrust disputes with physicians into a useful historical context. Part II will provide an analysis of H.R. 1304 and the reasons that AANA opposes it. Part III will discuss the recent history of anticompetitive conduct directed at CRNAs, focusing particularly on a recent American Medical Association Resolution directed against CRNAs and an ongoing antitrust action against anesthesiologists in Minnesota, where many CRNAs were dismissed from their positions with local hospitals as a result of what the Minnesota Association of Nurse Anesthetists alleges was an illegal conspiracy to exclude them from the market.

I. BACKGROUND INFORMATION ABOUT CRNAs

In the administration of anesthesia, CRNAs perform many of the same functions as physician anesthetists ("anesthesiologists") and work in every setting in which anesthesia is delivered including hospital surgical suites and obstetrical delivery rooms, ambulatory surgical centers, health maintenance organizations, and the offices of dentists, podiatrists, ophthalmologists, and plastic surgeons. Today, CRNAs administer more than 65% of the anesthetics given to patients each year in the United States. CRNAs are the sole anesthesia provider in 65% of rural hospitals which translates into anesthesia services for millions of rural Americans. CRNAs are also front line anesthesia providers in underserved urban areas, providing services for major trauma cases, for example.

CRNAs provide high quality care at a fraction of the cost of anesthesiologists. According to a study conducted by the Medical Group Management Association and published in the October, 1995 issue of Anesthesiology News, in calendar year 1994 the median annual income for nurse anesthetists was $72,001 but the median annual income for an anesthesiologist was $244,600.

CRNAs have been a part of the surgical team since the advent of anesthesia in the 1800s. Until the 1920s, anesthesia was almost exclusively administered by nurses. Though CRNAs are not medical doctors, no studies to date have demonstrated a difference between CRNAs and anesthesiologists in the quality of care provided, which is the reason no federal or state statute requires that CRNAs be supervised by an anesthesiologist. Anesthesia outcomes are affected by such factors as the provider's attention, concentration, and organization, and not whether the provider is a CRNA or an anesthesiologist. That is why the Harvard Medical School Standards in Anesthesia focus on monitoring the patient; the standards are based upon data that indicate that anesthesia incidents are usually caused by lack of attention to detail and insufficient monitoring of the patient.

The most substantial difference between CRNAs and anesthesiologists is that prior to anesthesia education, anesthesiologists receive a medical education while CRNAs receive nursing education. However, once they enter the work force, both professionals perform roughly the same services: (1) preanesthetic preparation and evaluation; (2) anesthesia induction, maintenance and emergence; (3) postanesthesia care; and (4) peri-anesthetic and clinical support functions, such as resuscitation services, acute and chronic pain management, respiratory care, and the establishment of arterial lines.

There are currently 87 accredited nurse anesthesia education programs in the United States lasting between 24-36 months, depending upon the university. As of 1998, all programs offer a master's degree level for advance practice nurses, and these programs are accredited by the Council of Accreditation of Nurse Anesthesia Educational Programs which is recognized by the U.S. Department of Education.

- CRNAs as Anesthesia Competitors

By the end of the nineteenth century, two developments - the discovery and utilization of anesthesia and the discovery and development of asepsis - resulted in an enormous expansion of the numbers and types of surgeries performed. Consequently, hospital construction flourished as the need grew for operating rooms to accommodate aseptic surgery. Simultaneously, demand grew for anesthesia specialists to focus their attention on the anesthesia care of patients while a physician performed surgery.

Nurses, whose hallmark is monitoring vital signs and administering medications, were a natural choice to provide anesthesia. Physicians turned increasingly to sisters in Catholic hospitals, as well as to other registered nurses from a growing number of nurse training programs, to administer anesthesia with wide acceptance. World War I accelerated the demand for qualified CRNAs. Advances made in medications and equipment and nurse anesthesia education during the war contributed to the nurse anesthetists' dominant position in the anesthesia services field.

Even before World War I, however, the growth and acceptance of the nurse anesthesia profession and its training programs provoked anticompetitive reactions from anesthesiologists. As early as 1911, in a harbinger of future anti-nurse anesthetist activity, counsel for the New York State Medical Society declared that the administration of an anesthetic by a nurse violated the law of the State of New York. The following year, the Ohio State Medical Board passed a resolution stating that only registered physicians could administer anesthesia.

Early efforts to crush the nurse anesthesia profession gained momentum as anesthesiologists organized in their opposition to nurse anesthetists. In 1915, anesthesiologists founded the Interstate Association of Anesthetists ("IAA") which successfully petitioned the Ohio State Medical Board to withdraw recognition of Cleveland's Lakeside Hospital as an acceptable training school for nurses on the grounds that Lakeside's use of nurse anesthetists violated the Ohio Medical Board Act. Nurses and prominent surgeons alike protested the board's decision, and succeeded in having it reversed.

Similarly, in 1917, the Kentucky State Medical Association, with prompting from organized anesthesiologists, passed a resolution prohibiting members from employing nurse anesthetists. In a test lawsuit brought by a nurse anesthetist, the Kentucky Court of Appeals ultimately rejected the proposition that the administration of anesthesia by a nurse constituted the unauthorized practice of medicine.

In 1921, another anesthesiologist group, the American Association of Anesthetists, commenced a boycott by adopting a resolution prohibiting its members from teaching nurse anesthetists.

Anesthesiologists also moved into the political arena, supporting legislation which would prohibit qualified nurse anesthetists from administering anesthesia.

Unlike anesthesiologists, the American College of Surgeons, comprised of physicians who utilized nurse anesthetists, opposed legislative prohibitions of nurse-administered anesthesia. In a 1923 resolution, they opposed all legislative enactments which would prohibit qualified nurses from administering anesthesia.

Surgeon support of nurse anesthetists, however, did not stop the anesthesiologists' efforts to keep nurse anesthetists from practicing their profession. In 1933, anesthesiologists associated with the Los Angeles County Medical Association brought a lawsuit against a nurse anesthetist claiming that nurse anesthetists' administration of anesthesia constituted the illegal practice of medicine. As had other courts, the California court found that the administration of anesthesia by nurse anesthetists was not the practice of medicine.

In 1937, the American Society of Anesthesiologists ("ASA") was formed. (The American Association of Nurse Anesthetists had been founded in 1931). Immediately after its inception, the ASA presented a master plan for the eventual elimination of nurse anesthesia to the American College of Surgeons. The plan specified that nurses should not be permitted to continue to provide anesthesia. It also provided, inter alia, that a provision should be included in the Minimum Standards of Hospitals (the forerunners of the Joint Commission on Accreditation of Hospitals' standards) directing that the department of anesthesia in each hospital shall be under the direction and responsibility of a well-trained physician anesthetist. The plan cautioned, however, "that no legislation should be forced until physician anesthetists can take over the work in a competent way."

World War II increased the number of anesthesiologists. See the discussion in United States of America v. The American Society of Anesthesiologists, 435 F. Supp. 147, 150 (SDNY, 1979). After the war, the anesthesiologists, as they sought to establish themselves in a civilian economy, renewed their activities against CRNAs. Between 1946 and 1948, the ASA conducted a campaign to discredit CRNAs in the eyes of the public. The campaign was successful in reducing the numbers of nurses attending nurse anesthesia training programs. The campaign was halted when the American Medical Association, the American College of Surgeons, and the Southern Surgical Society expressed their opposition to the ASA's negative publicity, and expressed their support of, and continued intention to utilize, CRNAs.

Attempts to eliminate CRNAs have often been more subtle. For example, in 1947 the ASA adopted an "ethical principle" prohibiting members in good standing from participating in nurse anesthesia programs and from employing or utilizing CRNAs. Measures to enforce the ethical guidelines included the threat to revoke the American Board of Anesthesiology certificates of physicians training nurse anesthetists.

- The Need for Vigorous Antitrust Enforcement

Based on historical and recent experience, the AANA believes that strong antitrust laws and enforcement serve to protect competition between anesthesiologists and CRNAs. CRNAs provide the same services as anesthesiologists with the same high degree of care. In the market for health services, a market which is widely considered complex and imperfect by economists, this sort of direct competition between rival professional groups should be vigorously defended. While many CRNAs practice in an anesthesia team which includes anesthesiologists and other ancillary support staff, CRNAs also practice as independent providers and receive direct reimbursement from multiple payors, as allowed by federal law. Independent CRNAs may function as independent contractors -- negotiating the best price for the service with different health entities. Therefore, many CRNAs compete directly with their physician colleagues -- anesthesiologists. Because of the prevalence of insurance in the health care field, recipients of anesthesia services are seldom the direct payors while physicians benefit from tremendous influence with insurance companies and others who actually pay for health care services. For this reason, the threat of swift and vigorous enforcement of the federal antitrust laws and the deterrent effect that *those laws have* on anticompetitive conduct are the most important protections that CRNAs have against anticompetitive conduct by physicians who may seek to exclude them from the market because they are lower cost competitors. In light of the power and influence of the medical community on staffing decisions, weakening the antitrust laws by new and sweeping immunity for negotiations between health care professionals and health care plans could undermine the ability of CRNAs to compete with anesthesiologists, or any other similarly positioned health professional.

Further, the current antitrust laws serve to protect the ability of other types of established health professionals to offer competitive health services. These groups include the nurse-midwives who provide obstetrical care to women in need; optometrists who provide post-op cataract eye care; occupational therapists who diagnose and provide rehabilitation care; and speech-language pathologists. It is no exaggeration to say that the antitrust laws have been a major force enabling nonphysician health professionals to compete with physicians when they provide comparable services. Such competition has been an enormous boon to consumers and third party payors who benefit from having a wider choice of highly qualified providers.

II. AANA's OPPOSITION TO THE ANTITRUST EXEMPTIONS IN H.R.1304

Representative Tom Campbell (R-CA) has introduced the Quality Health-Care Coalition Act of 1999 (H.R. 1304), a bill that would weaken the current antitrust laws when applied to health care providers. **AANA is OPPOSED to H.R. 1304**, as well as any legislative effort that would interfere with competition between health care providers, and threaten the ability of CRNAs to compete on fair and equitable terms with anesthesiologists.

If enacted H.R. 1304 would provide new and sweeping antitrust immunity for negotiations between health care professionals and health care plans. The bill's stated goal is to level the playing field between managed care plans and health care providers with respect to reimbursement and the terms and conditions of employment. In pursuit of that goal, the bill exempts negotiations between health care providers and plans from the reach of federal and state antitrust laws, regardless of whether such negotiations include exclusionary or unreasonable demands by rival providers, such as anesthesiologists.

The bill has two main provisions. The first provision immunizes negotiations between groups of health care professionals (of any size or composition) and a health plan regarding the terms of a contract to provide health care items or services covered by the plan. It does so by extending the same antitrust protections to those negotiations as currently apply to bargaining units recognized under the National Labor Relations Act ("NLRA"). Such protections are generally referred to as the labor antitrust exemptions.

The second provision exempts actions taken in good faith reliance on the first provision from antitrust criminal sanctions, civil damages, fees, and penalties beyond actual damages incurred. It also provides that the first provision shall not confer any right to participate in any collective cessation of *services* to patients not otherwise permitted by law. Although the language on "cessation of services," *i.e.* group boycott, is not entirely clear, it does suggest that health care providers could collectively take measures that would affect patients access to care, such as refusing to accept a plan's reimbursement.

AANA Opposes H.R. 1304 because enactment of the bill would:

- Eliminate Opportunities for CRNAs to Compete: The bill would have the effect of making it more difficult for CRNAs to compete with anesthesiologists for contracts with health care plans. That is because the bill would provide blanket antitrust immunity for bargaining demands by anesthesiologists that health plans impose significant limitations on practice opportunities for CRNAs or exclude them from the plans entirely.

  Under the bill, otherwise *per se* illegal conduct that occurs in the course of negotiations with health plans, such as price fixing, group boycotts, tying arrangements and customer or market allocation, would be entitled to immunity under the antitrust laws. The bill's wide ranging immunity would, for example,

permit health care professionals to make concerted demands about how much they should be paid for their services, who should be permitted to provide designated services and the terms and conditions under which designated services should be reimbursed.

Specifically, for CRNAs the bill's immunity would remove any legal bar to demands by anesthesiologists that CRNAs be excluded from a health plan because, for example, they fail to meet arbitrary licensing criteria, or that CRNAs be permitted to provide services for a health plan only on restrictive terms and conditions, such as costly and unnecessary supervision requirements.

- Eliminate Legal Incentives to Compete: The antitrust laws are an essential tool for CRNAs and other nonphysician providers to counteract the influence of physicians. For CRNAs, the antitrust laws not only deter anticompetitive conduct by rival providers and health plans, they also provide a powerful tool to combat anticompetitive conduct that threatens marketplace competition.

  The Act removes the antitrust laws as a deterrent to anticompetitive conduct when such conduct occurs in the course of negotiations with a health plan. In so doing, it eliminates any incentive that anesthesiologists have, under the antitrust laws, to compete with CRNAs on a fair or equitable basis and replaces it with an irresistible opportunity to collude on restrictive and exclusionary bargaining demands aimed squarely at excluding CRNAs' access to health plans.

- Undermine Nondiscrimination Requirements: The Balanced Budget Act of 1997 ("BBA") included important nondiscrimination requirements for nonphysician providers. Specifically, the BBA prohibited Medicare+Choice plans from discriminating against CRNAs solely on the basis of their state license or certification with respect to participation, reimbursement or indemnification. However, the BBA also stated that such nondiscrimination requirements did not prohibit Medicare+Choice plans from including providers only to the extent needed to meet the requirements of its patients or from establishing quality and cost control measures consistent with its responsibilities.

  Under the bill, anesthesiologists would be permitted to make concerted negotiating demands to Medicare+Choice plans that could effectively circumvent the nondiscrimination requirements. For example, they could negotiate restrictive educational or other professional criteria as a condition of participation, such as a residency in anesthesiology, which would have the effect of excluding CRNAs from the plan.

- Increase the Cost of Health Care and Harm Patients. The bill will inevitably increase the cost of health care by permitting high cost providers, such as anesthesiologists, to use their market power to increase their own reimbursement rates at the expense of more economic and efficient providers, such as CRNAs.

> Eliminating competition in this manner will also harm patients. Our nation's health care system operates on the promise that patients will benefit most in terms of quality, cost and access to care when there is vigorous competition between providers, such as CRNAs and anesthesiologists. The bill will effectively undermine that competition by eliminating the antitrust laws as a deterrent to even the most egregious anticompetitive negotiating demands by providers bent on excluding or limiting the scope of practice for CRNAs.

There is no level playing field for many CRNAs. The fact is that physicians still wield much greater power and influence with their fellow physicians and in the marketplace. And, based on past experience CRNAs can expect them to use that power to protect their jobs and their incomes as the industry downsizes to become more efficient.

The antitrust laws are an essential tool for CRNAs and other nonphysician providers to counteract the power and influence of physicians and hospitals. That is why AANA has grave concerns about the antitrust exemptions for health care professionals in H.R. 1304.

III. NURSE ANESTHETISTS HAVE FREQUENTLY BEEN VICTIMIZED BY ANTICOMPETITIVE CONDUCT ON THE PART OF PHYSICIAN COMPETITORS

Current practices in the field of anesthesia do not reflect the normal workings of the marketplace. Economics alone would suggest that hospitals would be anxious to use lower cost providers, such as nurse anesthetists, in order to reduce their costs, and thus their prices to patients and third-party payors. However, that it not always the case. Anesthesiologists have repeatedly used their influence to keep prices high by, for example, convincing hospitals to terminate nurse anesthetists so that the anesthesiologists would not face price competition. This is not the way the market should work or that our health care system should work. However, unless those most immediately affected by anticompetitive conduct -- nurse anesthetists -- are able to bring suit successfully under the antitrust laws, consumers will be forced to pay higher prices and, in some cases, have fewer choice of services, such as not being able to receive an epidural block during childbirth.

There are many examples of anticompetitive conduct that affects the ability of nurse anesthetists to compete for patients. Passage of H.R. 1304 would refocus much of this conduct to negotiations with health care plans, where discriminatory and anticompetitive restrictions could become part of the terms and conditions of participation and would act as an insuperable barrier to entry for CRNAs.

- Anticompetitive Conduct Directed Toward CRNAs

Attempts have been made to keep CRNAs from competing with anesthesiologists by creating various barriers to practice. Examples of barriers to practice include: (1) hospital medical staff bylaws that deny CRNAs clinical practice privileges, (2) restrictions on CRNAs clinical practice privileges, (3) the promulgation of inaccurate information about a surgeon's liability for CRNAs, (4) the formation of large anesthesiologist groups that use their increased control or influence with hospitals and health plans to limit or eliminate competition from CRNAs, and (5) exclusive contracting by powerful providers, such as hospitals. Whether specific barriers to CRNA practice constitute anticompetitive behavior under the antitrust laws obviously depend on the facts of each case. However, CRNAs need to be able to use the antitrust laws to the fullest when practice barriers result from attempts to price-fix, monopolize, or boycott. H.R. 1304 would eliminate the antitrust laws as an effective deterrent when anticompetitive conduct occurs during the negotiation process with health plans.

1. Hospital Medical Staff Bylaws Which Deny CRNAs Clinical Practice Privileges

Some physicians have created hospital medical staff bylaws that effectively eliminate the opportunity for independent CRNA practice. In one such case, the hospital, upon recommendation of a group of anesthesiologists, changed its bylaws to state that "nurse anesthetists could only practice in the institution if they were employees of the physician anesthesiologists." This bylaw effectively restricts an independent CRNA from applying for medical staff clinical practice privileges. Without the opportunity to obtain medical staff clinical practice privileges at a hospital, independent CRNAs do not have the ability to administer anesthesia to patients in that facility -- regardless of permission by state law -- and would have to become employees of an anesthesiologist group or some other entity in order to provide anesthesia services.

This kind of practice restriction would have costly consequences for consumers and third-party payors. That is because hospitals will almost certainly have to pay more for CRNAs who are employees of anesthesiologists than for independent CRNAs.

2. Restrictions on Clinical Practice Privileges of CRNAs

Even where CRNAs have the right to practice, in many institutions there have been situations where anesthesiologists, through the medical staff, have artificially restricted their scope of practice. If their scope of practice is limited, then CRNAs cannot compete with unlimited, "full service" anesthesiologists. Restrictions on scope of practice have included refusals to grant clinical practice privileges for regional anesthesia, insertion of invasive monitoring lines, postoperative pain management of patients, and refusal to allow administration of an epidural injection. Other CRNAs experience unnecessary limitations on which types of patients they may treat. These restrictions on clinical practice privileges are not related to education, ability or to what state law permits, but rather to an attempt to limit competition.

3. Promulgation of Inaccurate Information about a Surgeon's Liability for CRNAs

It is difficult for CRNAs to compete in the market when anesthesiologists use inaccurate information to persuade surgeons not to utilize CRNA services. In one such situation in Southern California, an anesthesiologist sent promotional and marketing letters to plastic surgeons, ophthalmologists and other physicians stating that the surgeons had increased liability if they used a CRNA rather than an anesthesiologist. It is important to understand that typically in cosmetic plastic surgery, the patient pays for the procedures, as insurance does not cover such

operations. Thus, plastic surgery is one of the few areas of health care where the market is sensitive to price. Plastic surgeons, recognizing the competitive pricing and high quality of care provided by CRNAs, have utilized CRNAs as practitioners for many years. However, inaccurate information regarding liability of the surgeons for care provided by CRNAs could have had a significant adverse influence on a surgeons' use of nurse anesthetists.

Anesthesiologists have also raised the specter of an increase in liability risk if CRNAs are not supervised by anesthesiologists. The law governing the liability of a surgeon for the negligence of a nurse anesthetist is precisely the same as the law which governs the liability of a surgeon for the negligence of an anesthesiologist. Liability depends on the facts of each case. Nonetheless, anesthesiologists continue to make such statements to discourage surgeons from working directly with CRNAs.

In this regard, the American Association of Nurse Anesthetists (AANA) has been engaged in a decade long battle to persuade the Health Care Financing Administration (HCFA) to remove the physician supervision requirement in the Medicare Conditions of Participation for Hospitals and Ambulatory Surgical Centers (ASCs). Given the anesthesiologists misuse of supervision requirements to create false perceptions about physician liability, HCFA was asked to remove the supervision requirement. HCFA proposed to do so in December, 1997. The proposed rule is still pending, in part due to the strong opposition generated by the American Society of Anesthesiologists (ASA). AANA has had to seek legislative relief so that the federal government will defer to the states on the issue of physician supervision of CRNAs (S. 866/H.R. 804) as it does in virtually every other area of health care.

4. Formation of Large Anesthesiologist Groups

Formation of anesthesiologist groups that have the potential to control a large share of the market also pose a threat to competition. Such groups are likely to have enough market power to force hospitals and other facilities to boycott low cost providers, such as CRNAs. As in any monopoly or near monopoly situation, the result is that consumers pay higher prices and have fewer choices of services.

Large anesthesiology groups have been able to monopolize anesthesia services in hospitals in a few major metropolitan areas. In those situations, competitors are likely to be prohibited from gaining access to the hospital, which eliminates competition altogether.

In 1994, there was a merger of two anesthesiologist groups (Middle Tennessee Anesthesiology, P.C. and Anesthesiology Consultants of Nashville, P.C.), both of

which served metropolitan Nashville, Tennessee and surrounding Davidson County. The new group, called Anesthesia Medical Group ("Group"), includes nearly 50% of the non-teaching anesthesiologists serving the metropolitan Nashville area. The Group also employs 105 of the 175 CRNAs practicing in the same area.

In the Nashville area there are 3,906 staffed hospital beds distributed among 12 hospitals. The Group is the sole anesthesia provider in two hospitals comprising one third of the available staffed hospital beds in Nashville. In a third hospital, with 571 staffed beds, the group does not have an exclusive arrangement, but provides approximately 65 percent of the anesthesia.

In total, the Group has approximately 50% of the practicing anesthesiologists in the area, controls 60% of the CRNAs in the area, and has exclusive or nonexclusive access to nearly one half of the areas staffed hospital beds. The market power of the Group appears to be well beyond the safety zones established in the Antitrust Division's and the FTC's Policy Statements for physician joint ventures, and because of that may have the ability to increase prices and reduce services for patients in the area.

- Exclusive Contracting by Powerful Providers

Texoma Medical Center, Inc. ("TMC"), a non-profit corporation that operates a hospital in Denison, Texas, provides an example of how exclusive contracting by a powerful provider can undermine competition from CRNAs. It is estimated that TMC provides medical care and treatment and surgical facilities for approximately 95 percent of the residents of Denison, Texas. TMC has approximately 15 to 20 surgeons on staff and has extended clinical privileges to four anesthesiologists and four CRNAs.

In January 1994, TMC's hospital administrator and CEO announced the hospital's intention to enter into an exclusive provider agreement "with a single source for all anesthesia care required by surgeons and patients of TMC." In conjunction with this announcement, certain physicians were requested to submit a proposal to the hospital for an exclusive provider agreement. No request for proposal was made to any of the CRNAs at the hospital with staff privileges, even though CRNAs charge less for anesthesia services than anesthesiologists. Presumably, CRNAs would have been allowed to continue providing services at the hospital only if they were employed by the exclusive provider group.

In order to keep the market competitive, three CRNAs and one anesthesiologist practicing at the hospital announced their intention to bring an antitrust suit against the hospital for exclusive dealing. The hospital subsequently dropped its exclusionary plan, but it might not have done so if the CRNAs had been hamstrung in their ability to bring an antitrust suit.

- Attempts by the American Medical Association to Restrict Practice Opportunities for CRNAs

The American Medical Association (AMA) has attempted to orchestrate a concerted campaign to restrict practice opportunities for CRNAs. In December 1998, its House of Delegates adopted a resolution calling for the AMA's support of legislative and regulatory proposals defining anesthesia as the practice of medicine. (AMA) Resolution 216. Specifically, the AMA Resolution 216 states:

1. "That anesthesiology is the practice of medicine."

2. "That the American Medical Association seek legislation to establish the principle in federal and state law and regulation that anesthesia care requires the personal performance or supervision by an appropriately licensed and credentialed doctor of medicine, osteopathy, or dentistry."

What the AMA meant to accomplish by stating that "anesthesiology is the practice of medicine," is to limit the administration of anesthesia *exclusively* to anesthesiologists and to ensure that CRNAs -- when they are permitted to practice at all-- are supervised by anesthesiologists at all times and in all settings. Such an interpretation would seriously restrict the ability of CRNAs to practice independently in settings, such as office-based or free-standings surgical centers, where the only physician available is likely to be the operating surgeon. It would also restrict their ability to provide anesthesia services in rural areas where no physician may be available.

Currently, the AMA has no way to put its unfair and discriminatory resolution into effect, except to call upon lawmakers to adopt such restrictions. However, under H.R. 1304, nothing would prevent AMA members from insisting that health plans adopt such a restrictive interpretation of the administration of anesthesia in order to exclude CRNAs from their plan or severely limit their participation. Such a restriction would penalize CRNAs and increase health care costs by eliminating healthy competition between anesthesiologists and nurse anesthetists and reducing the options now available to patients, payers and physicians to choose, if they desire, to obtain anesthesia services from independent CRNAs.

- Attempts at the State Level to Restrict the Scope of Practice for CRNAs

In addition to the AMA Resolution, there has been an increase in activity at the state level to circumscribe the practice opportunities of CRNAs. Many of these restrictions which are being hard fought in state legislatures, medical board and the like. Such restrictions could, however, be put into effect under H.R. 1304 through negotiations with health plans. These proposed restrictions include:

- Requiring CRNAs to be physician supervised in states that do not currently require such supervision.

- Requiring that anesthesiologists supervise CRNAs in states that already require physician supervision by requiring anesthesiologist supervision of CRNAs when anesthesiologists are "available;" by discouraging surgeons from working with CRNAs by requiring that physicians who supervise CRNAs meet criteria possessed only by anesthesiologists such as advanced education and training in anesthesia or hold "appropriate credentials."

- Requiring CRNA practice to be jointly regulated by the board of medicine and the board of nursing, rather than the board of nursing alone, and

- Reducing CRNAs' scope of practice, e.g., limiting the types of anesthesia that a CRNA can perform.

- Antitrust Actions Brought by CRNAs

CRNAs have brought actions against anesthesiologists for restricting competition. Although the antitrust exemption proposed in H.R. 1304 would not immunize all the types of exclusionary conduct catalogued below, these cases illustrate the fact that anesthesiologists have attempted to exclude CRNAs from the health care market using unfair and anticompetitive tactics. H.R. 1304 would immunize those same tactics when anesthesiologists employed them in connection with their negotiations with health care plans.

In Oltz v. St. Peter's Community Hospital, 861 F.2d 1440 (5th Cir. 1988), Oltz, a nurse anesthetist, sued four anesthesiologists and the hospital that gave them an exclusive contract to provide anesthesia services, under the antitrust laws. Oltz charged the anesthesiologists and the hospital with a group boycott, which can be a *per se* violation of the antitrust laws. The anesthesiologists settled before going to trial.

In affirming the district court's finding that the hospital joined the anesthesiologists' conspiracy to terminate Oltz's billing contract, the Ninth Circuit noted that the anesthesiologists had "pressured the hospital at St. Peter's to eliminate Oltz as a direct competitor." The court found that the anesthesiologists had threatened to boycott St. Peter's unless Oltz's independent billing status was terminated and that the anesthesiologists annual earnings at the hospital increased by forty to fifty percent after Oltz was terminated.

In Bhan v. NME Hospitals, Inc. 929 F. 2d 1404 (USCA Ninth Cir., 1991) a nurse anesthetist and an anesthesiologist were anesthesia providers in a small hospital in Manteca, California. Surgeons at the hospital decided to attract another anesthesiologist. When the third provider arrived the nurse anesthetist alleged that the anesthesiologist who was to be replaced tried to save his job by suggesting to the hospital administration an all-physician anesthesia policy and the elimination of the CRNA. The CRNA brought suit under the antitrust laws arguing that a physician only anesthesia policy was a coercive boycott. The Ninth Circuit ruled that nurse

anesthetists and anesthesiologists directly compete for purposes of the antitrust laws but the trial court held that the Hospital's conduct had to be evaluated under the rule of reason and the case was dismissed.

In Anesthesia Advantage, Inc. v. Metz, 708 F. Supp. 1171, 1175 (10th Cir. 1990), four nurse anesthetists in the Denver, Colorado area and their professional corporation, The Anesthesia Advantage, Inc. ("TAA"), brought suit against several anesthesiologists and Humana Hospital. The nurse anesthetists alleged *per se* violations of the antitrust laws, including price fixing, market allocation and a group boycott. The charges were based on (1) a hospital-instituted "call schedule" for anesthesiologists and the anesthesiology staff's recommendation to adopt guidelines for supervising nurse anesthetists; (2) a conspiracy to induce another hospital to reject a fee-for-service proposal by TAA to provide out-patient ambulatory surgery anesthesia on pre-arranged days; and (3) an attempt to persuade a third hospital to reject a proposal that the hospital use TAA for an obstetric epidural anesthesia program.

The nurse anesthetists alleged that they were "illegally squeezed out of business by anesthesiologists because the presence of CRNAs forced down the market price for anesthesiologist services."

The Tenth Circuit Court of Appeals reversed the trial court's dismissal of the case, and some of the defendants eventually settled the case, by among other things, agreeing that they would not interfere in the future with CRNAs' right to practice anesthesia.

- The Current Case in Minnesota

A recent case that illustrates the unfair and anticompetitive tactics employed by anesthesiologists to exclude CRNAs is that brought by the Minnesota Association of Nurse Anesthetists (MANA). MANA has alleged that a group of anesthesiologists sought to eliminate CRNAs as lower cost competitors and to seize unfettered control over the market in the pricing of anesthesia services; as a result of this scheme many CRNAs at three of the largest Minnesota hospitals were fired from their jobs.

MANA is currently engaged in a lawsuit which seeks to bring this unlawful conduct to an end and to restore competition to the marketplace. MANA is currently appealing the dismissal of its complaint.

Minnesota nurse anesthetists, in their suit, have alleged that for years, anesthesiologists have allocated territories between themselves and engaged in organized boycotts of both individual CRNAs and CRNA groups. MANA alleges that beginning ten years ago and lasting until very recently, there had been virtually no competition between any of the anesthesiology groups in the state and that groups had allocated the various hospitals among themselves and entered into de facto or actual exclusive agreements with those hospitals.

CRNAs are natural competitors with anesthesiologists for the provision of anesthesia services. Despite this fact, in Minnesota and many other states, anesthesiologists make over four times as much money as CRNAs. The reason for this, at least in part, is that in Minnesota anesthesiologists have established and maintained substantial market power through a number of organized efforts which have successfully put them in a position to control anesthesia pricing and the method in which anesthesia is provided.

Unfortunately, the result in many hospitals is that the method by which anesthesia is provided is based largely upon the reimbursement potential and the profitability to the anesthesiologist. The allegations in the Minnesota suit exemplify how this power works against competition. The annual average income of an anesthesiologist in the Twins Cities area is believed to exceed the average in every other state, going as high in some cases as one-half million dollars or more.

It is our understanding that in some cases, and possibly many cases, the cost of the anesthesia services provided in connection with a surgery may exceed the cost of the surgery itself by a substantial amount. This is because the anesthesiologists have created barriers to entry and foreclosed the market for anesthesia not only to CRNAs but to competing anesthesiologists who might seek to enter the Minnesota market and compete on pricing. The allegations and evidence in the law suit suggest that:

1. Anesthesiologists have misrepresented government requirements for reimbursement as quality of care requirements. In other words, through the smoke screen of patient quality of care, they have imposed requirements that anesthesiologists be involved in, or at least get paid for, virtually every aspect of the anesthesia procedure, even though many of these aspects of the anesthesia procedure can be performed and are performed by CRNAs alone. In particular, federal and state laws, as well as AANA's certification requirements, permit CRNAs a wide scope of practice to provide virtually any anesthesia service. As stated earlier, CRNAs are the sole anesthesia provider in 75% of rural hospitals and therefore, provide all the services.

Nevertheless, under the guise of patient safety, anesthesiologists have introduced limitations on CRNAs' scope of practice. These limitations appear in hospital by-laws, written hospital procedures or in some cases, in unwritten hospital policies. For example, anesthesiologists have restricted CRNAs' ability to (1) perform regional anesthesia, (2) place arterial lines, and (3) place epidurals. AANA believes it is not a coincidence that Medicare and other third party payors pay substantial amounts of money for these procedures. Anesthesiologists who attempt to allow CRNAs to perform such procedures have been threatened by other anesthesiologists and often their state associations. Interestingly, procedures such as intubation and extubation, which are equally challenging but do not have a corresponding high rate of reimbursement, are routinely performed by CRNAs without objection by anesthesiologists.

2. Anesthesiologists have engaged in conspiracies with hospital personnel to prevent CRNAs from practicing on an independent basis in hospitals, downgrading CRNA status as health care providers, and other restrictive practices which impede the CRNAs' ability to independently provide anesthesia services. Anesthesiologists have also limited CRNAs' scope of practice.

Anesthesiologists' control of the market has extended to attempts to eliminate a supply of CRNAs in the Minnesota market. Anesthesiologists have recently refused to assist the school for CRNAs which provides new graduate CRNAs -- again under the guise of quality of care concerns. Also, the anesthesiologists' refusal to permit education in other aspects of anesthesia has threatened student ability to meet requirements to become "certified" as certified registered nurse anesthetists (CRNAs). AANA requires advanced clinical experience in these areas before it will extend certification.

Perhaps the most egregious example of the anesthesiologists' attempt to obtain a stranglehold on the market for anesthesia has occurred in the past two years during which the anesthesiologists have entered into a conspiracy to eliminate CRNAs altogether in Minnesota as economic competitors and to force them to work directly for the anesthesiologists. In this way, they can ensure that while CRNAs are still performing the work for them, CRNAs will be unable to affect or compete in the areas of pricing and other quality of service concerns.

The law suit also alleges that through a campaign which included: (1) the use of improper and fraudulent billing to Medicare and other third party payers, (2) widespread dissemination of inaccurate and misleading statements disparaging CRNAs and their abilities to practice anesthesia, and (3) the limitations on scope of practice referred to above, anesthesiologists have coerced four of the major hospitals in the state of Minnesota including Unity Hospital, Mercy Hospital, St. Cloud Hospital, and Abbott-Northwestern Hospital, to terminate all of their CRNA employees and to compel them to work for the anesthesiologists. Because the anesthesiologists control the market for anesthesia, CRNAs were left with the choice of leaving their families, selling their houses and seeking employment outside the state.

Had it not been for the lawsuit brought by MANA, it would not be an exaggeration to state that by now competition in the area of anesthesia services between the CRNAs and the anesthesiologists would be non-existent.

Just a Turf Battle?

No doubt there will be some who believe that our concerns are unjustified, simply the problems of a turf battle between health care professionals. To a large degree, this is a turf battle, but an important one in which today's consumer has a major stake. If the antitrust laws are weakened, it is not just nurse anesthetists who will be pushed out of the

health care market, it is yet another consumer choice which falls by the wayside and a good possibility that anesthesia prices could needlessly rise.

Consider the comments of ASA President John B. Neeld, Jr., M.D. In his article "Market Factors Demand the Evolution of the Care Team", in the Georgia Society of Anesthesiology Newsletter (date uncertain). He clearly sets out his ideas about the role of anesthesiologists and nurse anesthetists in the health care system. He said in part:

> "In addition to the reduction in demand for services and the reduction in reimbursement for those services, the supply side of Anesthesia personnel has also changed. There is now an excess number of Physician and Anesthetists competing for the same positions. An excess supply has brought the compensation levels that new Anesthesiologists are willing to accept close in the salary levels enjoyed by Anesthetists that the differential is negligible, particularly when one places a reasonable value on the greater skills, education, and professionalism that the physicians bring to a practice. **Replacement of Anesthetists by Anesthesiologists is by no means a death knell for these personnel; most practices will always have a need for a certain number of non-physician practitioners to provide economically viable coverage for underutilized anesthetizing locations.** Doing the right thing is frequently unpopular; doing the wrong thing in this case will deprive patients of the opportunity for improved care and deprive our specialty of the opportunity for continued improvements in our knowledge base and technology that are dependent upon the maintenance of our Educational and Research Institutions and upon the continued attraction of the best and brightest medical students into Anesthesiology. Each of us must step forward and do the proper thing for our patient population, our Specialty, and for Anesthesiologists and Anesthetists. **Anesthetists who add value to practices and are loyal to the true concept of a Care-Team should be retained and rewarded; those who do not should be replaced by our Young Physician Colleagues."** (Emphasis added)

We think Dr. Neeld clearly states the agenda of the American Society of Anesthesiologists (ASA) which appears to be: CRNAs who cooperate with us have their place but those who don't should be replaced by anesthesiologists. We don't know what other conclusion you could reasonably draw from Dr. Neeld's comments. Bottom line: play ball or be replaced.

That agenda, reinforced by the ASA's request to the AMA to issue a resolution that "anesthesia is the practice of medicine", continues to make the puzzle even more clear. And if this legislation were to be enacted, it would give the anesthesiologists the legal green light to move ahead and boycott, price-fix or engage in other illegal activities in order to push nurse anesthetists out of the market. This resolution has caused some organizations to contact AANA to inquire whether this requires them to employ only anesthesiologists.

But these issues are raised not only by CRNAs but in fact others as well.

In his book, Not What the Doctor Ordered, How to End the Medical Monopoly in Pursuit of Managed Care, (McGraw Hill, 1998) Jeffery C. Bauer, Ph.D., explains at length and in specifics, how organized medicine has, over the years, sought to constrain nonphysician providers from gaining a foothold in the healthcare delivery system. His chapter on nurse anesthetists and anesthesiologists provides an interesting perspective from a health care futurist and medical economist. I offer some excerpts to explain his position. He states in part:

> "In the context of this chapter's main theme, I have saved the best example for last. (To be clear and fair, it is the example, not the professional group, that is best. Nurse practitioners, nurse midwives, and nurse anesthetists are all excellent in their different areas of practice). The CRNA story illustrates perfectly the benefits of competition from qualified nonphysician practitioners and the harmful effects of doctors' anticompetitive efforts to control the market. In particular, it shows why persistent enforcement of antitrust law, something very different from health reform, is needed to protect consumers' welfare from doctors' monopoly when acceptable substitutes are available. . .".
>
> "My reason for featuring the market for anesthesia services is actually quite strong from the economic perspective. Physicians may have been unsuccessful in their ongoing attempts to eliminate nurse anesthetists as an alternative, but they have been remarkably successful in depriving American consumers of the potential economic benefits of potential competition. In other words, doctors have controlled the market to their own economic benefit, which means consumers have been paying uncompetitive prices for anesthesia services. How else could one explain the fact that anesthesiologists have consistently earned more than twice as much as nurse anesthetists while providing the same service?"
>
> "The principal measure of economic harm has been the fee that anesthesiologist receive for 'supervising' nurse anesthetists. Unable to prevent state legislatures from licensing CRNAs, anesthesiologists have used their influence with health insurance plans (often as owners or directors) to make sure that payment flowed through the doctor's account. For years, many private health plans have had various schemes that allowed anesthesiologists to charge their full fee for services provided by CRNAs operating under their supervision. (The term is 'medical direction' in the arcane language of Medicare reimbursement. This technicality allows an anesthesiologist to be partially reimbursed for 'medically directing' up to four CRNAs at a time. It is nice work if you can get it . . . and having monopoly power helps."
>
> "You can easily guess the rest of the story: the doctor they pays the nurse anesthetist a lower amount for performing the service, and he pockets the often substantial difference. This difference between an anesthesiologist's fee and the

cost of the CRNA who actually provided the service might be justifiable if supervision were necessary, but it isn't. This practice is a textbook example of economic exploitation. It is a sign of unwarranted economic power which makes consumers pay more than what is necessary or fair. It reminds me of featherbedding, the discredited labor practice of using more workers than are necessary. Thanks to modern technology and excellent training, CRNAs do not need medical 'supervisors' any more than railroads need superfluous brakemen and conductors riding in a caboose".

"Finally doctors have used their economic power to deny or restrict hospital privileges for nurse anesthetists. Even in states were CRNAs have full rights to independent practice and direct reimbursement, anesthesiologists have regularly prevented their nonphysician counterparts from having equal access to operating rooms, the site where most anesthesia is administered. This practice constitutes a significant barrier to entry, one of the key indicators of monopoly power in economic theory and antitrust law.

This brief look at the market for anesthesia services shows that medical monopolists have many ways to suppress competition, even when qualified nonphysician practitioners receive licenses for independent practice. CRNAs have achieved much of the recognition sought by other advanced practice nurses, but consumers are still denied a free, fully informed choice in the marketplace because doctors continue to defend 'captain of the ship' authority with the outdated argument that they are unique (i.e., better). The many successes of CRNAs in a still imperfect market remind us that the medical monopoly must be fought on many fronts.

To armchair economists, the story might seem to have a happy ending. Anesthesiologists' incomes have fallen dramatically in the past few years, which might be interpreted as a sign that competition has finally prevailed in this market. More than one force could be at work here, however, so do not jump to simple conclusions. Managed care has certainly exerted some downward pressure on money paid to hospital-based physicians. An oversupply of anesthesiologists is also believed to be a major explanatory factor. Anesthesiologists' professional associations are already working on plans to reduce the number of training positions and to restrict the entry of foreign medical graduates into residency programs.

These efforts must not become red herring that divert our attention from the market's long-term problems, unjustifiable restrictions on consumer choice and related barriers to entry. Believe me, anesthesiologists have not lost interest in this issue just because they have realized they are too numerous. They are pushing like never before to control CRNAs. Monopolists do not go down easily when their incomes are threatened. Intensive, anesthesiologist-led efforts to place restrictions on nurse anesthetists have been initiated within the past two years in

several areas of the country, including the bellwether states (in terms of health policy) like Ohio, Minnesota, New York, New Jersey, Pennsylvania, and Oregon."

"A proposal made by the Oregon delegation to the 1997 mid-year meeting of the AMA House of Delegates serves as fitting proof that doctors are still fighting all advanced practice nurses to retain their monopoly power:

> Whereas, Increasing pressure by special interest groups has persuaded state legislators to introduce legislation unjustifiably expanding scopes of practice of alternative and allied health workers; and Whereas, Many healthcare workers seek to legislate their ability to practice medicine, rather than obtain a high level of expertise and competence through medical school education and training; and Whereas, Medical decisions for patients are best made by medical doctors; and Whereas, There is considerable confusion on the part of the public and some legislators regarding the qualifications and training of healthcare workers versus medical doctors; and Whereas Education of the public and legislature needs to occur to replace confusion and ignorance with facts; therefore be it RESOLVED, That is the it is the policy of the American Medical Association to protect the public by supporting medical doctors against efforts advanced by alternative providers seeking increased medical control of patients by legislatively expanding their scopes of practice without physician directions and state boards of medical examiners oversight."

Dr. Bauer concludes that the resolution was reaffirmed by the Delegates as a statement of existing AMA policy.

Conclusion

In conclusion, providing antitrust exemptions for physicians will harm nonphysician providers and their patients. That is because antitrust exemptions can and likely will be misused by physicians to discriminate against nonphysician providers with whom they compete for patients and for health care dollars.

Despite the fact that plain economics would suggest otherwise, many nonphysician providers are experiencing difficulty contracting with health plans because most, if not all, are controlled by physicians. Permitting physicians to obtain blanket antitrust immunity for their negotiations with health plans will make that situation worse and quite possibly foreclose those opportunities for CRNAs and other nonphysician providers completely. Many of the arguments made in the guise of "quality of care" are merely nothing more than a veiled attempt to grab greater control of the health care market and to enhance physician incomes.

Recent activity by the AMA and in state legislatures has made it clear to AANA that physicians are searching for ways to limit competition from nonphysician providers and will use any means at their disposal to accomplish those ends. The Congress and this Committee should not assist them by abolishing the antitrust laws that protect nonphysician providers from exclusionary and discriminatory treatment by physicians and health plans. To do so would undermine the health care system itself and penalize nonphysician providers and their patients by tipping an already unlevel playing field on its head in favor of physicians.

Thank you for your consideration of our views. I look forward to responding to your questions.