



UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition

May 11, 2011

The Honorable Rodney Ellis
The Honorable Royce West
The Senate of the State of Texas
P.O. Box 12068
Austin, Texas 78711

Dear Senators Ellis and West:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition¹ ("FTC staff") are pleased to respond to your invitation for comments on Texas Senate Bills 1260 and 1339 ("S.B. 1260 and S.B.1339" or "the Bills") and the regulation of Advanced Practice Registered Nurses ("APRNs").² S.B. 1260 would remove physician supervision and delegation requirements for APRNs, allowing these health care professionals to practice to the full extent of their education and training. S.B. 1339 similarly would remove physician oversight requirements and grant diagnostic and prescription-writing authority to APRNs,³ but prescription-writing authority would require 500 hours of practice under the supervision of a physician or another APRN with full prescriptive authority. You have asked FTC staff to analyze the "likely competitive impact" of S.B. 1260 and S.B. 1339. Based on current evidence, the Bills' elimination of supervision and delegation requirements appears to be a procompetitive improvement in the law that likely will benefit Texas health care consumers, and FTC staff therefore urge the Texas legislature to adopt either S.B. 1260 or S.B. 1339.

In fact, in its January 2011 report to the 82nd Texas Legislature, the Texas Legislative Budget Board staff found that Texas's "site-based, delegated model of prescriptive authority limits patient access to affordable, quality healthcare providers, particularly in rural and health professional shortage areas."⁴ The Institute of Medicine (IOM) recently noted similar concerns

¹ This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission ("Commission") or of any individual Commissioner. The Commission has, however, voted to authorize staff to submit these comments.

² Letter from Hon. Rodney Ellis and Hon. Royce West, Texas State Senate, to Susan DeSanti, Director, Office of Policy Planning, Federal Trade Commission (Apr. 6, 2011) [hereinafter Ellis/West Letter].

³ *Id.* (discussing requirements in Tex. Occ. Code Ann. § 157, which governs the conditions under which physicians may delegate diagnostic and prescriptive authority to nurse practitioners and physician assistants).

⁴ TEXAS LEGISLATIVE BUDGET BOARD STAFF, TEXAS STATE GOVERNMENT EFFECTIVENESS AND EFFICIENCY: SELECTED ISSUES AND RECOMMENDATIONS 297 (Jan. 2011) (submitted to the 82nd Texas Legislature) [hereinafter

with restrictive state scope of practice laws and specifically recommended that the FTC “[r]eview existing and proposed state regulations concerning advanced practice registered nurses [and urge states] with unduly restrictive regulations . . . to amend them to allow advanced practice registered nurses to provide care to patients in all circumstances in which they are qualified to do so.”⁵ We therefore urge the Texas Legislature to consider the impact of the current restrictions on the scope of practice of APRNs, and to adopt either S.B. 1260 or S.B. 1339. Doing so would allow APRNs to provide health care services in a manner consistent with their training and the protection of patients.⁶

Interest and Experience of the Federal Trade Commission

The FTC is charged with enforcing the FTC Act, which prohibits unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.⁷ Effective competition is at the core of America’s economy;⁸ vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, more choices, and greater innovation.

Health care competition is of particular importance to the economy and consumer welfare. For this reason, anticompetitive restraints in health care markets have long been a key focus of FTC law enforcement,⁹ research,¹⁰ and advocacy.¹¹ Of direct relevance to the proposed

BUDGET BOARD STAFF REPORT]. As you also noted in your letter, “physician supervision requirements vary based on the APRN’s practice setting, . . . the various requirements create a complicated regulatory scheme,” and “APRNs at an alternative practice site must find a supervising physician that lives or practices within 75 miles,” which may exclude APRNs otherwise willing to practice in rural and underserved areas. Ellis/West Letter, *supra* note 2, at 1-2.

⁵ INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 10-11 (2011) [hereinafter IOM REPORT]. The IOM was established in 1970 as “the health arm of the National Academy of Sciences” and “is an independent, nonprofit organization that works outside of government to provide unbiased and authoritative advice to decision makers and the public.” About the Institute of Medicine, *available at* <http://www.iom.edu/About-IOM.aspx>.

⁶ We do not offer an opinion as to whether S.B. 1260 or S.B. 1339 is a preferable regulatory environment for Texas.

⁷ Fed. Tr. Comm’n Act, 15 U.S.C. § 45.

⁸ *See National Society of Professional Engineers v. United States*, 435 U.S. 679, 695 (1978) (“The heart of our national economy long has been faith in the value of competition.”).

⁹ *See generally* FED. TR. COMM’N, FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Sept. 2010), *available at* <http://www.ftc.gov/bc/110120hcupdate.pdf>; Fed. Tr. Comm’n Website, Competition in the Health Care Marketplace, *available at* <http://www.ftc.gov/bc/healthcare/antitrust/index.htm>.

¹⁰ *See, e.g.*, FED. TR. COMM’N & U.S. DEP’T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), *available at* <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> [hereinafter FTC/DOJ, A DOSE OF COMPETITION]; Fed. Tr. Comm’n, Centers for Medicare & Medicaid Servs., & Dep’t of Health & Human Servs. Office of Inspector Gen’l, Workshop Regarding Accountable Care Organizations and Implications Regarding Antitrust, Physician Self-Referral, Anti-Kickback and Civil Monetary Penalty (CMP) Laws (Oct. 5, 2010), *available at* <http://www.ftc.gov/opp/workshops/aco/index.shtml>; Fed. Tr. Comm’n, Workshops on Emerging Health Care Competition and Consumer Issues (Oct. 30, 2008 & Nov. 21, 2008), *available at* <http://www.ftc.gov/bc/workshops/hcbio/index.shtml>; FED. TR. COMM’N, EMERGING HEALTH CARE ISSUES: FOLLOW-ON BIOLOGIC DRUG COMPETITION (JUNE 2009), *available at* <http://www.ftc.gov/os/2009/06/P083901biologicsreport.pdf>; Fed. Tr. Comm’n, Workshop on Clinical Integration in Health Care: a Check-Up (May 29, 2008), *available at* <http://www.ftc.gov/bc/healthcare/checkup/index.shtml>; Fed.

Texas APRN legislation, the FTC has closely followed issues relating to competition by health care providers such as nurse practitioners, physician assistants, and dental hygienists. Recently, FTC staff urged several states to reject or narrow restrictions that curtail competition among health care providers because they limit patients' access to health care and raise prices.¹² In particular, staff examined APRN scope of practice restrictions that appear to have exceeded what is necessary to protect consumers.¹³ As noted above, the recent IOM Report on the Future of Nursing recognizes the importance of this competition perspective and, more specifically, the Commission's expertise and experience in addressing anticompetitive restrictions on the scope of various healthcare professionals' practice.¹⁴

I. Background

A. APRNs

APRNs are licensed under the Texas Nursing Practice Act.¹⁵ Under this Act, "advanced practice nurse" means a registered nurse approved by the Texas Board of Nursing on the basis of

Tr. Comm'n, Workshop on Innovations in Health Care Delivery (Apr. 24, 2008), *available at* <http://www.ftc.gov/bc/healthcare/hcd/index.shtm>.

¹¹ Advocacy by the Commission and its staff may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.*, Letter from FTC Staff to Hon. Daphne Campbell, Florida House of Representatives (Mar. 22, 2011) (regarding proposed legislation to eliminate certain restraints on the scope of practice of Advanced Registered Nurse Practitioners), *available at* <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>; Letter from FTC Staff to Hon. Timothy Burns, Louisiana Legislature, (May 1, 2009) (regarding proposed restrictions on mobile dentistry), *available at* http://www.ftc.gov/os/2009/05/V090009_louisianadentistry.pdf; Fed Tr. Comm'n & U.S. Dep't of Justice Written Testimony before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 2008), *available at* <http://www.ftc.gov/os/2008/09/V080018illconlaws.pdf>; FTC Amicus Curiae Brief in *In re Ciprofloxacin Hydrochloride Antitrust Litigation* Concerning Drug Patent Settlements Before the Court of Appeals for the Federal Circuit (Case No. 2008-1097) (Jan. 2008), *available at* <http://www.ftc.gov/os/2008/01/080129cipro.pdf>; FTC/DOJ, A DOSE OF COMPETITION, *supra* note 10.

¹² *See, e.g.*, Letter from FTC Staff to Hon. Daphne Campbell, *supra* note 11; Letter from FTC Staff to Hon. Timothy Burns, *supra* note 11; Letter from FTC Staff to Elain Nekritz, Illinois Legislature (May 29, 2008) (regarding proposed limited service clinic (LSC) regulations), *available at* <http://www.ftc.gov/os/2008/06/V080013letter.pdf>; Letter from FTC Staff to Massachusetts Dep't of Health (Sept. 27, 2007) (regarding proposed LSC regulations), *available at* <http://www.ftc.gov/os/2007/10/v070015massclinic.pdf>. Many of these advocacy efforts have been influential in preserving competition. For example, following the above-referenced advocacy letters, the Louisiana and Illinois legislatures rejected the proposed restrictions on competition, and Massachusetts followed FTC staff's recommendations in adopting its final LSC regulations.

¹³ *See, e.g.*, Letter from FTC Staff to Hon. Daphne Campbell, *supra* note 11; Letter from FTC Staff to Kentucky Cabinet for Health and Family Services (Jan. 28, 2010) (regarding restrictions on the scope of practice for nurse practitioners, and others, that would have applied in LSCs but not in other limited care settings, such as urgent care centers), *available at* <http://www.ftc.gov/os/2010/02/100202kycomment.pdf>; FTC Staff Comment Before the Alabama State Board of Medical Examiners Concerning the Proposed Regulation of Interventional Pain Management Services (Nov. 3, 2010) (regarding restrictions on the scope of practice of certified registered nurse anesthetists, a specialized sub-category of APRNs), *available at* <http://www.ftc.gov/os/2010/11/101109alabamabrdme.pdf>.

¹⁴ IOM REPORT, *supra* note 5, at 5, 10, 105 (2011).

¹⁵ Tex. Occ. Code Ann. § 301.001 *et seq.* (2011) (Nursing Practice Act).

the nurse having completed an advanced educational program, which must include “pharmacology and related pathology education.”¹⁶ In addition, the Texas Board of Nursing has promulgated rules requiring that the educational program, at a minimum, include a master’s degree, and meet “certain standards set by the [nursing] board or by a national accrediting body recognized by the board.”¹⁷ Nationally, “[m]ore than a quarter of a million nurses are APRNs . . . who hold master’s or doctoral degrees and pass national certification exams.”¹⁸

According to the January 2011 Budget Board Staff Report, “Texas has some of the most restrictive scope of practice guidelines in the U.S. for APRNs.”¹⁹ According to the report, the number of advanced practice nurses is lower in states with restrictive regulatory environments, and these restrictions may “limit the expansion of retail clinics, which generally employ APRNs to provide a limited range [of] primary healthcare.”²⁰ The Budget Board Staff Report also noted that approximately 26 percent of Texas’s population lives in a health professional shortage area and that “Texas is below the U.S. average in its primary care physicians-to-population ratio.”²¹ Finally, the report stated that researchers “have compared physician and APRN patient outcomes and found them comparable” and “no findings have shown better health outcomes for patients in states with more restrictive regulatory environments.”²²

B. S.B. 1260 and S.B. 1339

S.B. 1260 would remove physician supervision and delegation requirements, allow APRNs to practice independently, and define an APRN’s scope of practice to include “advanced assessment, diagnosing, prescribing, and ordering.” Under the new law, APRN status would be based upon (1) successful completion of a graduate-level program accredited by a national accrediting body and (2) current certification by a national certifying body recognized by the Texas Board of Nursing.²³

¹⁶ Tex. Occ. Code Ann. § 301.152(c)(1).

¹⁷ Texas Board of Nursing, Rules and Regulations, at Chapter 221, *available at* <http://www.bon.state.tx.us/nursinglaw/pdfs/bon-rr-0111.pdf>.

¹⁸ IOM REPORT, *supra* note 5, at 23; *see also* BUDGET BOARD STAFF REPORT, *supra* note 4, at 299 (although certification exams are administered nationally, licensure requirements are determined on a state-by-state level and may vary widely). Different states refer to advanced practice registered nurses by various names and abbreviations, including “APRNs,” “ARNPs,” “nurse practitioners,” etc. For an overview of nurse practitioner requirements generally, *see* IOM REPORT, *supra* note 5, at 26, table 1 (types of practice) and 38-45.

¹⁹ BUDGET BOARD STAFF REPORT, *supra* note 4, at 299 (further noting “[t]wenty states and the District of Columbia allow APRNs to practice as autonomous, or very nearly autonomous, healthcare providers”). *See also* IOM REPORT, *supra* note 5, at 157-61 (chart summarizing the state practice regulations for nurse practitioners).

²⁰ BUDGET BOARD STAFF REPORT, *supra* note 4, at 300.

²¹ *Id.*

²² *Id.*

²³ These amendments would be to Chapter 301 of the Occupations Code, the Nursing Practice Act, as well as conforming amendments and deletions to other chapters, including Chapter 157 of the Occupations Code (governing the authority of physicians to delegate certain medical acts).

S.B. 1339 also would revise current Texas law to allow APRNs to make diagnoses and to prescribe and order prescription drugs and medical devices. Unlike S.B. 1260, however, S.B. 1339 would require APRNs seeking independent prescriptive authority to first practice with prescriptive authority for a minimum of 500 hours under the supervision of a physician or APRN who already has prescriptive authority.²⁴

II. Likely Effects on Texas Health Care Consumers

Texas health care consumers are likely to benefit from the passage of either S.B. 1260 or S.B. 1339 for several reasons, including lower health care costs, greater access to care, and greater choice among settings where health care is provided.

Both S.B. 1260 and S.B. 1339 are likely to reduce the cost of basic health care services in two important ways. First, APRN care is generally less expensive. As noted by the Texas Legislative Budget Board staff, “[a]ll APRNs who bill the Texas Medicaid Program are directly reimbursed at 92 percent of the physician’s rate” and if they bill Medicare “they are paid 85 percent of the fee paid to physicians.”²⁵ Second, the cost of APRN care itself would be decreased; under the current law, supervision and delegation requirements create administrative costs for APRNs, and these costs would be reduced under either of the Bills. Some of these cost savings may be passed on to public and private third-party payers, and ultimately to Texas health care consumers, in the form of lower prices.

Both S.B. 1260 and S.B. 1339 likely will encourage greater usage of APRNs, which will also play an important role in improving access to health care services by Texas consumers. The Texas Legislative Budget Board staff noted that APRNs “have helped mitigate the effects of a general practice physician shortage” and that reduced restrictions on APRNs “would increase the availability of lower-cost primary healthcare providers.”²⁶ The IOM, too, recently recognized the important role that APRNs can play in improving access to health care.²⁷ Among other things, the IOM observed that “[r]estrictions on scope of practice . . . have undermined the nursing profession’s ability to provide and improve both general and advanced care.”²⁸ FTC staff agree that the Bills likely will reduce barriers to entry and permit health care providers greater flexibility to offer basic health care through APRN-staffed offices and clinics.

To the extent both S.B. 1260 and S.B. 1339 would increase the deployment of APRNs in a variety of health care delivery settings and thereby widen the range of choices available to consumers, both Bills also are likely to spur innovation in health care delivery and increase competition to provide basic health care services. This may generate additional benefits for

²⁴ See S.B. 1339, amendments to Tex. Occ. Code Ann. §§ 301.152, 301.357, and 157.051.

²⁵ BUDGET BOARD STAFF REPORT, *supra* note 4, at 302.

²⁶ *Id.* at 297.

²⁷ See generally IOM REPORT, *supra* note 5 (especially Summary, 1-15).

²⁸ *Id.* at 4.

Texas health care consumers. For example, APRN-staffed clinics generally offer weekend and evening hours, which provides greater flexibility for patients, and may provide competitive incentives for other types of clinics to offer extended hours as well.²⁹

In addition, APRNs have played an important role in the recent increase in so-called limited service clinics (“LSCs”) in many states. LSCs typically are staffed by APRNs³⁰ and offer consumers a convenient way to obtain basic medical care at competitive prices.³¹ As the January 2011 Budget Board Staff Report noted, restrictions on APRNs’ scope of practice may limit both the number and types of LSCs available to Texas consumers.³²

III. Potential Consumer Protection Concerns Raised by Reduced Scope of Practice and Supervision Requirements

Patient safety or consumer protection concerns may justify licensure requirements and scope of practice restrictions.³³ FTC staff recognize that particular health care procedures may require specialized training or heightened supervision if they are to be safely administered. There does not appear to be any evidence, however, that the safety of care provided by APRNs varies according to differences in physician supervision or scope of practice requirements.³⁴

²⁹ Cf. Rena Rudavsky, Craig Evan Pollack, & Ateev Mehrotra, *The Geographic Distribution, Ownership, Prices, and Scope of Practice at Retail Clinics*, 151 ANNALS INTERNAL MED. 315, 317 (2009) (“In a random sample of 98 [limited service] clinics, all had weekday and weekend hours and 95 (97%) had evening hours (after 6 p.m.) on weekdays.”).

³⁰ See generally William M. Sage, *Might the Fact that 90% of Americans Live Within 15 Miles of a Wal-Mart Help Achieve Universal Health Care?*, 55 U. KAN. L. REV. 1233, 1238 (2007) (describing the size and scope of LSCs); Mary Kay Scott, Scott & Company, *Health Care in the Express Lane: Retail Clinics Go Mainstream*, at 22 (Sept. 2007) (report prepared for the California HealthCare Foundation), available at <http://www.chcf.org/publications>.

³¹ See Massachusetts Dept. Pub. Health, Commonwealth to Propose Regulations for Limited Service Clinics: Rules May Promote Convenience, Greater Access to Care (Jul. 17, 2007), available at http://www.mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=dphpressrelease&prFile=070717_clinics.xml. The types of care offered at LSCs are similar to those offered in urgent care centers and other limited care, outpatient settings. See, e.g., Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients Visits*, 27 HEALTH AFFAIRS 1272, 1279 (September/October, 2008).

Evidence shows that the quality of care provided by APRNs in retail clinics is “similar to that provided in physician offices and urgent care centers and slightly superior to that of emergency departments.” Ateev Mehrotra et al., *Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses*, 151 ANNALS INTERNAL MED. 321, 326 (2009) (analysis of 14 quality metrics for commonly treated ailments, including ear, strep, and urinary tract infections, and finding “[f]or most measures, quality scores of retail clinics were equal to or higher than those of other care settings”). *Id.*

³² BUDGET BOARD STAFF REPORT, *supra* note 4, at 300.

³³ In competition terms, licensure requirements or scope of practice restrictions may sometimes offer an efficient response to certain types of market failure that can occur in professional services markets. See CAROLYN COX & SUSAN FOSTER, FEDERAL TRADE COMMISSION, BUREAU OF ECONOMICS, *THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION*, 5-6 (1990), available at <http://www.ftc.gov/be/consumerbehavior/docs/reports/CoxFoster90.pdf>.

³⁴ FTC staff have not found empirical studies indicating a relationship between additional APRN supervision requirements and greater safety. See IOM REPORT at 85-161, 98-99 (discussing nursing scope-of-practice issues and quality of care, and noting “[n]o studies suggest that care is better in states that have more restrictive scope-of-

Available evidence suggests that APRNs generally are safe providers of health care services when they provide services consistent with their training.³⁵ More broadly, the available empirical evidence indicates that APRN-delivered care “across settings, is at least equivalent to that of physician-delivered care as regards safety and quality,”³⁶ and that increased APRN care may even be associated with improved outcomes for particular disease indications or patient populations.³⁷ Studies of LSCs – which, as discussed above, offer certain basic primary care services and tend to be staffed by APRNs without direct on-site physician supervision – indicate that the clinics provide high-quality health care.³⁸ In addition, studies of APRN subspecialties, such as certified registered nurse anesthetists, suggest safe delivery of care.³⁹

practice regulations for APRNs than in those that do not”); Brian Dulisse & Jerry Cromwell, *No Harm Found When Nurse Anesthetists Work Without Supervision by Physicians*, 29 HEALTH AFFAIRS 1469, 1474 (2010) (reviewing Medicare data for more than 480,000 patients and finding “data do not support the hypothesis that patients are exposed to increased surgical risk if nurse anesthetists work without physician supervision”).

³⁵ See, e.g., BUDGET BOARD STAFF REPORT, *supra* note 4, at 300 (discussing research demonstrating safety of APRNs); Florida House of Representatives Staff Analysis, Bill # HB 699 CS Health Care (Mar. 8, 2006), at note 5 and accompanying text (citing Linda Aiken, director of the University of Pennsylvania's Center for Health Outcomes and Policy Research, for the proposition that “over 100 studies have examined the care delivered by nurse practitioners and none demonstrated a negative impact of their care on health”).

³⁶ Eileen T. O’Grady, *Advanced Practice Registered Nurses: The Impact on Patient Safety and Quality*, in AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, PATIENT SAFETY AND QUALITY: AN EVIDENCE-BASED HANDBOOK FOR NURSES (ed. Ronda G. Hughes) 2-606 (2008). The study surveys empirical research on APRN quality and safety generally, *id.* at 2-605 – 2-607, as well as research regarding safety and quality of care for APRN subspecialties. *Id.* at 2-602 – 2-604 (regarding nurse midwives, nurse anesthetists, and clinical nurse specialists). See also Sue Horrocks et al., *Systematic Review of Whether Nurse Practitioners Working in Primary Care Can Provide Equivalent Care to Doctors*, 324 BMJ 819 (2002) (British review of 11 trials and 23 observational studies finding increased satisfaction and no health disparities for patients treated by nurse practitioners versus physicians).

³⁷ See, e.g., Mary D. Naylor et al., *Transitional Care of Older Adults Hospitalized with Heart Failure: A Randomized, Controlled Trial*, 52 J. AM. GERIATRIC SOC’Y 675, 682-684 (2004) (AP[R]N-directed intervention associated with increased time to first readmission or death and reduced total number of rehospitalizations in care of older adults and management of heart failure); *cf.* Jack Needelman et al., *Nurse-Staffing Levels and the Quality of Care in Hospitals*, 346 N. ENGL. J. MED. 1715, 1719-20 (2002) (increased care by registered nurses – which include APRNs as subset – associated with improved outcomes/reduced adverse events for medical and surgical patients).

³⁸ Ateev Mehrotra et al., *Comparing Costs and Quality of Care at Retail Clinics with that of Other Medical Settings for 3 Common Illnesses*, 151 ANNALS INTERNAL MED. 321, 326 (2009).

³⁹ See, e.g., A.F. Smith, et al., *Comparative Effectiveness and Safety of Physician and Nurse Anaesthetists: A Narrative Systematic Review*, 93 BRIT. J. ANAESTHESIA 540, 544 (2004) (review article examining U.S. and foreign studies finding “no recent, high-level evidence that there are significant differences in safety between different anaesthesia providers”); Paul F. Hogan, et al., *Cost Effectiveness Analysis of Anesthesia Providers*, 28 NURSING ECON. 159, 161 (2010) (“there are no studies that show a significant difference between CRNAs and anesthesiologists in patient outcomes.”); Dulisse & Cromwell, *supra* note 34 (no increased surgical risk when unsupervised CRNAs are used); Michael Pine, et al., *Surgical Mortality and Type of Anesthesia Provider*, 71 AM. ASS’N NURSE ANESTHETISTS J. 109, 116 (2003) (“After adjustment for differences in case mix, clinical risk factors, hospital characteristics, and geographic location, the current study found similar risk-adjusted mortality rates whether anesthesiologists or CRNAs worked alone.”).

Conclusion

Requiring physician supervision of APRNs imposes costs on Texas health care consumers. Both S.B. 1260 and S.B. 1339 would reduce those costs, and the Bills likely would improve access and increase choices for Texas health care consumers as well. Absent evidence that the current statutory restrictions are required to address patient harms, FTC staff urge the Texas legislature to enact either S.B. 1260 or S.B. 1339 to remove those restrictions. If particular medical procedures require heightened supervision requirements, staff recommends the legislature tailor supervision requirements to address those particular services.

We appreciate your consideration of these issues.

Respectfully submitted,

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