American Association of
NURSE ANESTHESIOLOGY

May 22, 2025

Assistant Attorney General Abigail Slater
United States Department of Justice
Antitrust Division
950 Pennsylvania Avenue NW
Washington, DC 20530

Submitted electronically via: Regulations.gov (Docket No. ATR-2025-0001)

Dear Assistant Attorney General Slater:

On behalf of the 65,000 members of the American Association of Nurse Anesthesiology (AANA), I wish to respectfully submit comments in response to the Department of Justice Anticompetitive Regulations Task Force's solicitation of public comments to support Executive Order 14192, "Unleashing Prosperity Through Deregulation"[1], and Executive Order 14219, "Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Initiative".[2]

Certified Registered Nurse Anesthetists (CRNAs) are Advanced Practice Registered Nurses (APRNs) who are autonomous anesthesia providers through their extensive training and preparation. Despite this, CRNAs face an anticompetitive practice landscape – created through federal and state policymaking and supported by efforts by special interest groups – that has resulted in higher costs and lower competition, incentivized inefficient models of anesthesia care delivery, and limited the availability of healthcare choice for consumers and veterans.

The Federal Trade Commission's (FTC) own findings agree with this assessment, stating that, "Physician supervision requirements may raise competition concerns because they

[1] Executive Order 14192. Unleashing Prosperity Through Deregulation. 90 Fed. Reg. 9065 (February 6, 2025). Issued January 31, 2025. https://www.govinfo.gov/content/pkg/FR-2025-02-06/pdf/2025-02345.pdf
[2] Executive Order 14219. Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Agenda. 90 Fed. Reg. 10583 (February 25, 2025). Issued February 19, 2025. https://www.govinfo.gov/content/pkg/FR-2025-02-25/pdf/2025-03138.pdf

effectively give one group of health care professionals the ability to restrict access to the market by another, competing group of health care professionals, thereby denying health care consumers the benefits of greater competition."[3]

The following comments: provide a background on CRNA practice, outline the most egregious examples of this anticompetitive landscape and the ways in which it has impeded the efficient and cost-effective delivery of high-quality anesthesia care, and propose policy solutions in alignment with President Trump's Executive Orders.

Key Comments and Requests

- The Centers for Medicare & Medicaid Services should remove onerous and unnecessary physician supervision requirements on CRNAs in Medicare Part A.
- The Department of Veterans Affairs should grant full practice authority to CRNAs to provide VA medical centers with the flexibility to choose efficient models of anesthesia care.
- The Department of Health and Human Services, Department of Labor, and Department of the Treasury should enforce the federal provider non-discrimination statute to prevent discriminatory commercial payer practices.
- State laws create an outdated, restrictive, and anticompetitive practice environment and cause inefficiencies in the healthcare system.
- Special interest groups have put great effort into promoting and maintaining this outdated, restrictive, and anticompetitive practice environment for their own benefit.

Section I: CRNA Practice Background

CRNAs must be board certified and must participate in continuing education and recertification every 4 years to practice. CRNAs have four years of education to get their Bachelor of Science in Nursing (BSN). They are required to practice for a minimum of one year as critical care nurses, with most CRNAs averaging three years practicing as critical care nurses. Additionally, all CRNAs have completed either a Masters or Doctoral program in nurse anesthesia and average just under 10,000 clinical hours before practicing as a CRNA. CRNAs work at the head of the table and in a consultative, team-based approach to care. CRNAs take the lead in anesthesia before, during, and after surgery and are leaders within the surgical care team. As independently licensed professionals, CRNAs are

[3] Federal Trade Commission. Policy Perspectives: Competition Advocacy and the Regulation of Advanced Practice Nurse Practitioners. Pgs. 1-2. March 2014. https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

responsible and accountable for making judgments and taking actions in their professional healthcare practice.[4]

CRNAs provide expert anesthesia and pain management care across diverse clinical settings and are trained and licensed to care for all patients, including those with complex medical conditions. CRNAs provide over 50 million anesthetics annually across the United States. In some states, CRNAs are the sole anesthesia providers in nearly 100 percent of rural hospitals, affording these medical facilities obstetrical, surgical, trauma stabilization, and pain management capabilities. Only six states require supervision of CRNAs in their nursing/medicine laws or rules and only one of those states, New Jersey, requires physician anesthesiologist supervision solely for the ambulatory surgical setting.

Section II: Peer-Reviewed Evidence Demonstrating CRNA Quality and Safety

There exists clear evidence demonstrating the safety of CRNAs autonomously delivering anesthesia care. A peer-reviewed study published in the Journal of Medicare Care in 2016 looked at anesthesia-related complications for CRNA-only care, physician anesthesiologist-only care, and a team-based approach to care, and found there were no differences in complication rates based on delivery model.[5] This corroborates an earlier peer-reviewed study published in Health Affairs in 2010 that looked at the differences in outcomes in states that had opted out of Medicare's supervision requirement for CRNAs and found no difference in outcomes compared to states that maintained supervision requirements.[6] A comprehensive literature review on anesthesia staffing models completed by the Cochrane Library in 2014 further reinforced these findings and found that there could be no definitive statement made about the superiority of any one anesthesia delivery model with respect to safety or adverse outcomes.[7] And Temple University, at the request of the Department of Veterans Affairs (VA), studied CRNA practice across the country and independently recommended removing restrictions on CRNA practice within the VA.[8]

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[4] AANA Code of Ethics for the Certified Registered Nurse Anesthetists, July 18, available at: https://issuu.com/aanapublishing/docs/code_of_ethics_for_the_certified_registered_nurse_?fr=sZGY1YTU2NDAxMjU.

[5] Negrusa B., et al., Scope of practice laws and anesthesia complications: No measurable impact of certified registered nurse anesthetist expanded scope of practice on anesthesia-related complications, Medical Care (June 2016).

[6] B. Dulisse and J. Cromwell, No Harm Found When Nurse Anesthetists Work Without Physician Supervision, Health Affairs, 29: 1469-1475 (2010).

[7] Lewis SR, Nicholson A, Smith AF, Alderson P. Physician anesthetists versus non-physician providers of anesthesia for surgical patients, Cochrane Database of Systematic Reviews, Issue 7. Art. No.: CD010357. DOI: 10.1002/14651858.CD010357.pub2, (2014).

[8] Baumle, DeAnna. September 2022. Policy Brief: Certified Registered Nurse Anesthetist Scope of Practice Laws. Temple University. https://www.va.gov/STANDARDSOFPRACTICE/docs/CRNA_PolicyBrief_Temple.pdf.

Section III: Unnecessary Medicare Physician Supervision and Opt-Out Requirements

The Centers for Medicare & Medicaid Services (CMS) places onerous and unnecessary physician supervision requirements on CRNA practice as part of the Hospital, Critical Access Hospital, and Rural Emergency Hospital Conditions of Participation (CoPs) and the Ambulatory Surgical Center Conditions for Coverage (CfCs) per 42 CFR §482.52(a)(4) and (c), §485.639(c) (2) and (e), §416.42 (b)(2) and (c), and § 485.524 (d)(3ii) and (d)(5) for Medicare Part A. **CMS should remove these supervision requirements; they are only in place because of political pressure from a small number of providers who have successfully lobbied in their support**.

CMS originally rescinded these requirements in a final rule on January 18, 2001,[9] but CMS ultimately withdrew this final rule and replaced it with a cumbersome bureaucratic opt-out process for states to individually remove the requirements.[10] These requirements represent clear regulatory overreach: there exist no enabling statutes mandating that CMS implement physician supervision requirements of CRNAs or the state supervision opt out process.[11] Furthermore, CRNAs have been Medicare Part B providers since 1989, billing Medicare directly at 100% of the Medicare Physician Fee Schedule (PFS); physician supervision of CRNAs is not a Condition for Payment under Medicare Part B. Finally, no other health care provider specialty is required to go through the process of lobbying state governors to opt out of federal regulations for the purposes of meeting CoP or CfC requirements.

Physician supervision requirements contribute to inefficiencies and waste in the Medicare program and serve to increase costs, particularly for rural facilities that rely upon CRNAs to provide anesthesia care. Physician supervision requirements under the CoPs and CfCs incentivize the use of Medicare Part B anesthesiologist medical direction payment models. These payment models allow physician anesthesiologists to spuriously collect 50% of the fee per case for up to four concurrent cases performed by CRNAs, while consistently failing to meet Medicare regulatory requirements. This anesthesia practice model results in significant lapses, as made evident by a 2012 study in *Anesthesiology,* the official journal of the American Society of Anesthesiologists.[12] This study found that at even a 1:2 anesthesiologist to CRNA ratio, lapses occurred on 35 percent of days.

[9] 66 Fed. Reg.4674, January 18, 2001.
[10] 66 Fed. Reg. 56762, November 13, 2001.
[11] See 66 Fed. Reg. 4674, 4685 et seq., January 18, 2001, and 66 Fed. Reg. 56762, 56768 et seq. November 13, 2001.
[12] Epstein RH, Dexter F. Influence of supervision ratios by anesthesiologists on first-case starts and critical portions of anesthetics. Anesthesiology. 2012 Mar;116(3):683-91. doi: 10.1097/ALN.0b013e318246ec24. PMID: 22297567.

There is no evidence to support the continued use of these requirements. As noted in *Section II: Peer-Reviewed Evidence Demonstrating CRNA Quality and Safety***,** there exists clear evidence demonstrating the safety of CRNAs autonomously delivering anesthesia care. These supervision requirements are more stringent than most state laws. To date, half of all states have opted out of the CMS requirement for physician supervision of CRNAs. Furthermore, 44 states do not have any requirements for physician supervision of CRNAs in their nursing/medicine laws or rules. If these requirements were necessary to protect patients, CMS would not allow states to opt out.

Physician supervision of CRNAs under the Medicare program remains in place only due to political pressure from a small number of providers who have successfully lobbied for policies that lead to wasteful spending and that benefit their own special interests, while robbing taxpayers of their hard-earned money. Medicare supervision requirements deny facilities the flexibility to choose the most cost-effective and efficient model of anesthesia care while limiting patient access to care. Rescinding these requirements would align Medicare policy with clinical evidence and would allow facilities the flexibility to choose the anesthesia delivery model that meets their needs, thus reducing operating costs.

Section IV: Exclusion of CRNAs in the Department of Veterans Affairs' APRN Full Practice Authority Regulations

On December 14, 2016, the Department of Veterans Affairs (VA) released a final rule[13] on APRNs which extended full practice authority to three of the four APRN roles (Nurse Practitioners, Clinical Nurse Specialists, and Certified Nurse Midwives), excluding only CRNAs, at 38 CFR § 17.415. **VA should include CRNAs in this regulation to grant CRNAs full practice authority, thereby providing individual VA facilities the flexibility to choose the optimal and most efficient anesthesia care model.**

This final rule capriciously disadvantaged CRNA practice within the Veterans Health Administration (VHA), particularly relative to the three other APRN roles, and misaligned VA policy compared to the current policies of the United States Armed Forces. *To wit*, Defense Health Agency Administrative Instruction 6025.07 (dated November 8, 2023 and currently in force)[14], related to the provision of anesthesia services within the military, states that, "Anesthesia is recognized as a specialty by both nursing and medicine and both Anesthesiologists and CRNAs are recognized as licensed independent practitioners based

[13] Advanced Practice Registered Nurses, 81 Fed. Reg. 90198 (December 14, 2016). Codified at 38 CFR § 17.415.

[14] "Utilization of Anesthesia Services in the Military Medical Treatment Facilities" (Defense Health Agency, 2023). https://www.health.mil/Reference-Center/DHA-Publications/2023/11/08/DHA-AI-6025-07

on their respective scope of practices and will be held to these standards in credentialing and medico-legal issues."

In the VA's Supplementary Information provided with the final rule, the VA itself rebuffed arguments against full practice authority for CRNAs and, in fact, agreed with comments supporting CRNA full practice authority. In short, the VA did not grant full practice authority to CRNAs despite the body of evidence presented within the rule and its supporting documents, which clearly do support granting full practice authority to CRNAs.

The VA also noted in the final rule, in response to the American Society of Anesthesiologists' (ASA) claim that there existed no anesthesiologist shortage within the VHA, that such claims "were not substantiated by evidence." However, the VA went on to decide that, *despite the lack of evidence*, they agreed "with the sentiment of this argument." Yet, in the months and years following the final rule, there have been multiple cases of the VA having to postpone or cancel surgeries due to a lack of anesthesia staff; these instances were directly exacerbated by VA's decision not to grant CRNAs full practice authority across the VHA.[15,16]

Further, the VA highlighted in the final rule evidence that 25% of VA facility Chiefs of Staff "reported problems recruiting or hiring anesthesiologists." More recently, the VA's Office of the Inspector General in the *OIG Determination of Veterans Health Administration's Severe Occupational Staffing Shortages Fiscal Year 2024* report, published in August 2024, identified 31 VA facilities with a severe anesthesiology shortage, representing 22% of all VA facilities. The same report identified 10 VA facilities with a severe shortage of CRNAs.

The VA noted in the final rule their receipt of 45,915 comments in support of full practice authority for APRNs, and a further 9,613 comments in support of full practice authority for CRNAs specifically. These comments made note of the several contexts in which CRNAs enjoy full practice authority, including in the Army, Navy, and the Air Force; the evidence showing that APRN practice improves access and quality of care while reducing costs; and their ability to help alleviate delays at the VA. And, unlike the comments submitted by the ASA, the VA agreed with comments supporting extending full practice authority to CRNAs but again claimed that it was unnecessary due to the lack of shortage in anesthesia care.

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[15] "Critical Deficiencies at the Washington DC VA Medical Center," (Department of Veterans Affairs, Office of the Inspector General, 2018). https://www.oversight.gov/sites/default/files/oig-reports/VAOIG-17-02644-130.pdf

[16] "Dozens of surgeries at Denver VA hospital put off because of doctor shortage" (David Migoya, 2017). https://www.denverpost.com/2017/10/12/dozens-surgeries-denver-va-hospital-put-off-because-doctor-shortage/

This statement regarding a lack of anesthesiologist shortages has been proven incorrect by the cancellation and delay of over one hundred surgeries in the years since CRNAs were excluded from full practice, by persistent problems hiring anesthesiologists, and the anesthesia shortages that the VA's Office of the Inspector General identified in its August 2024 report.

The VA also agreed in the final rule that studies have shown that "anesthesia care by CRNAs was equally safe with or without physician supervision," and found that claims that there was no shortage of anesthesiologists "were not substantiated by evidence," and even acknowledged that over one fourth of VA facilities experience issues hiring anesthesiologists. Yet, the "extensive (…) campaign against granting full practice authority to CRNAs," led them to make a political decision, instead of one informed by the evidence.

The VA's decision not to grant full practice authority to CRNAs across the entire VHA system has created a blatantly anticompetitive. CRNAs working within the VHA cannot practice independently to the full scope of their education and training, even if the VA facility in which they practice is located in a state in which they can practice independently to the full scope of their education and training. This anticompetitive inflexibility has impacted VA medical centers' ability to implement flexible anesthesia care models and their ability to attract and retain CRNAs and has created a system that has directly resulted in limiting veterans' access to care.

Section V: Non-Enforcement of Provider Non-Discrimination (Public Health Service Act Section 2706(a)) and Discriminatory Commercial Payer Policies

The Department of Health and Human Services (HHS), Department of Labor (DOL), and Department of the Treasury (Treasury) - hereafter referred to as the Tri-Departments - have yet to promulgate regulations to implement and enforce the federal provider non-discrimination provision at 42 USC §300gg-5,[17,18] which took effect on January 1, 2014, and prohibits health plans from discriminating against qualified licensed healthcare professionals, such as CRNAs, solely based on their licensure. **The Tri-Departments**

[17] Patient Protection and Affordable Care Act. Sec. 1201, Subpart 1.

[18] The statutory provision reads as follows: "(a) Providers.--A group health plan and a health insurance issuer offering group or individual health insurance coverage shall not discriminate with respect to participation under the plan or coverage against any healthcare provider who is acting within the scope of that provider's license or certification under applicable State law. This section shall not require that a group health plan or health insurance issuer contract with any healthcare provider willing to abide by the terms and conditions for participation established by the plan or issuer. Nothing in this section shall be construed as preventing a group health plan, a health insurance issuer, or the Secretary from establishing varying reimbursement rates based on quality or performance measures."

should enforce this existing provider non-discrimination provision to prevent commercial payers from engaging in discriminatory payment practices.

Congress has made clear that federal implementation of this statute to date has been inadequate. In December 2020, Congress passed (and President Trump enacted) the Consolidated Appropriations Act of 2021, (Public Law 116–260), which included the No Surprises Act. Section 108 of the No Surprises Act required the Secretaries of the Tri-Departments to issue a proposed rule, no later than January 1, 2022, to implement the provider non-discrimination protections under Section 2706(a) of the Public Health Service Act, with a final rule issued no later than six months after the conclusion of the 60-day comment period on the proposed rule.[19] Based on the regulatory timeline required under Section 108 of the No Surprises Act, a final rule should have been promulgated *nearly three years ago* to permanently implement these protections against provider discrimination. The Biden Administration, however, never even issued a proposed rule, despite clear Congressional intent.

In the interim, group health plans and health insurance issuers have demonstrably discriminated against CRNAs on the basis of licensure with respect to reimbursement for anesthesia services. There are numerous examples since 2022 (when the final rule implementing Section 2706(a) of the PHS Act was supposed to have been issued) of plans/issuers reducing payment to 85% of those plans'/issuers' fee schedules for services billed with the Healthcare Common Procedure Coding System (HCPCS) modifier "QZ", denoting CRNA services provided without medical direction by a physician. These include (but are not limited to):

- Cigna reduced reimbursement for services billed with the QZ modifier to 85 percent in March 2023.[20] (Cigna explicitly stated that they reduced CRNA reimbursement on the basis of licensure in an August 2024 response letter to AANA).
- Anthem Blue Cross Blue Shield of California, Connecticut, Maine, Missouri, Nevada, New York, Ohio, and Virginia reduced reimbursement for services billed with the QZ modifier to 85 percent in November 2024.[21]

[19] Public Law 116–260, https://www.congress.gov/bill/116th-congress/house-bill/133/text/enr
[20] Cigna Healthcare. (2023, March 12). Reimbursement Policy Commercial: Anesthesia Professional Services. https://static.cigna.com/assets/chcp/secure/pdf/resourceLibrary/clinReimPolsModifiers/R39_Anesthesia_Professional_Services.pdf
[21] Anthem Blue Cross and Blue Shield. (2024, November 1). Commercial Reimbursement Policy: Anesthesia Services – Professional. https://files.providernews.anthem.com/5106/ME-Anesthesia-Services-policy-06122024.pdf

- Kaiser Foundation Health Plan of Washington reduced reimbursement for services billed with the QZ modifier to 85 percent in December 2024 (*policy later rescinded*).[22]
- Medical Mutual of Ohio reduced reimbursement for services billed with the QZ modifier to 85 percent January 2025.[23]

Given that the QZ modifier applies only to CRNA services provided without medical direction by a physician, and that these policies do not impact other anesthesia providers (nor did these plans/issuers implement similar policies with respect to other anesthesia providers), it stands to reason that these plans/issuers are in effect discriminating against CRNAs based on their licensure.

These examples belie CMS' assertion in sub-regulatory guidance, in the form of a 2015 Frequently Asked Questions (FAQ) document, which states that, "Until further guidance is issued, the Departments will not take any enforcement action against a group health plan, or health insurance issuer offering group or individual coverage, with respect to implementing the requirements of PHS Act Section 2706(a) as long as the plan or issuer is using a good faith, reasonable interpretation of the statutory provision."[24] These plans/issuers have plainly not acted in good faith; yet the Tri-Departments have actively chosen to ignore Congressional intent in not enforcing Section 2706(a) of the PHS Act. The Tri-Departments' failure to enforce Section 2706(a) of the PHS Act will likely embolden other plans/issuers to issue similar policies.

Such discrimination suppresses competition, inflates costs, and denies patients the ability to receive anesthesia care from qualified anesthesia providers. It also directly impairs small, independent CRNA businesses by limiting fair access to networks and contracts. By refusing to enforce provider non-discrimination laws, the Tri-Departments have permitted insurance companies to ignore federal provider non-discrimination protections, undermining non-physician providers nationwide and creating an anticompetitive practice environment.

Section VI: Special Interest Actions and Lobbying Efforts

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[22] Kaiser Foundation Health Plan of Washington. (2024, July 25). Modifiers. https://wa-provider.kaiserpermanente.org/static/pdf/provider/communications/letters/20240725-modifier-policy.pdf

[23] Medical Mutual of Ohio. (2025, January 24). Reimbursement Policy: Anesthesia. https://www.medmutual.com/-/media/MedMutual/Files/Providers/CorporateReimbursementPolicies/Anesthesia_Reimbursement_Policy.pdf

[24] Center for Consumer Information and Insurance Oversight. Affordable Care Act Implementation FAQs (Set 27). May 26, 2015. https://www.cms.gov/cciio/resources/fact-sheets-and-faqs/downloads/aca-faqs-part-xxvii-moop-2706-final.pdf. Accessed: May 15, 2025.

Governmental policymaking (or lack thereof) is not the only contributing factor that has led to such an anticompetitive environment for CRNA practice. Special interest groups have engaged in efforts clearly aimed at limiting independent, non-physician healthcare provider practice, including independent CRNA practice, thereby creating an anticompetitive landscape tilted toward physicians.

For example, the American Medical Association (AMA) operates a Scope of Practice Partnership[25] with the sole purpose of defeating legislation and regulations that allow independent practice for non-physician healthcare providers within the scope of their education and training.

According to the AMA, one aim of this Scope of Practice Partnership effort is to provide team-based care that is higher quality and more cost-effective.[26] Yet, as detailed in the sections above, restricting CRNA practice generally has the opposite effect: delays or cancellations in care, higher costs for anesthesia care, reduced choice and access for patients, and limited access to insurance networks and fair contracts for providers. There also exists a lack of evidence that anesthesia care provided independently by CRNAs is less safe or less effective than anesthesia care provided by physician anesthesiologists. As will be described in *Section VII: Restrictive State Laws and Regulations*, the AMA's Scope of Practice Partnership has supported outdated laws and regulations that artificially inhibit care delivery and patient access to care.

Specific to the Department of Veterans Affairs (VA), the VA noted in the 2016 VA final rule, "Advance Practice Registered Nurses",[27] that they "received 104,256 comments against granting full practice authority to VA CRNAs," which resulted entirely from the American Society of Anesthesiologists' (ASA) heavy lobbying efforts. Further, the VA noted that the ASA established a website to facilitate the submission of comments, which provided language to ASA members suggesting that granting full practice authority to CRNAs would eliminate the team-based concept of anesthesia care that the VA established in VHA Handbook 1123, Anesthesia Service. The VA noted that "these comments were not substantive in nature and were akin to a ballot box," and fully rebuffed the content of ASA's comments by concluding that "establishing full practice authority to VA APRNs, including CRNAs, would not eliminate any well-established team-based care."

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[25] American Medical Association. Scope of Practice Partnership. https://www.ama-assn.org/topics/scope-practice-partnership. Accessed: May 15, 2025.
[26] American Medical Association. The AMA is fighting scope creep. https://www.ama-assn.org/amaone/why-we-fight-fighting-scope-creep. Accessed: May 15, 2025.
[27] Advanced Practice Registered Nurses, 81 Fed. Reg. 90198 (December 14, 2016). Codified at 38 CFR § 17.415.

The ASA's lobbying effort also promoted the claim there existed no anesthesiologist shortage within the VHA at the time the final rule was promulgated, though the VA found that these claims "were not substantiated by evidence." As noted in *Section IV: Exclusion of CRNAs in the Department of Veterans Affairs' APRN Full Practice Authority Regulations*, the VA went on to decide that, *despite the lack of evidence*, they agreed "with the sentiment of this argument." Yet, in the months and years following the final rule, there have been multiple cases of the VA having to postpone or cancel surgeries due to a lack of anesthesia staff. These postponements and cancellations were directly exacerbated by VA's decision not to grant CRNAs full practice authority across the VHA, a decision that was heavily influenced by ASA's lobbying efforts.[28,29]

The ASA additionally submitted an unsolicited *amicus curiae* brief in the case of *American Association of Nurse Anesthesiology v. Xavier Becerra, Secretary of the United States Department of Health and Human Services, et al.* (Case No. 1:24-CV-01657) in the United States District Court for the Northern District of Ohio Eastern Division. AANA's complaint seeks to compel the government to fulfill its duties to enforce the provider non-discrimination provision described in *Section V: Non-Enforcement of Provider Non-Discrimination (Public Health Service Act Section 2706(a)) and Discriminatory Commercial Payer Policies*.

ASA's brief did nothing to advance the ongoing litigation or address the current issues before the court and again put forth ASA's unsupportable claims that physician anesthesia providers provide superior services to nurse anesthesia providers. As noted in *Section II: Peer-Reviewed Evidence Demonstrating CRNA Quality and Safety*, the preponderance of evidence demonstrates that outcomes are similar when comparing anesthesia care provided independently by CRNAs and anesthesia care provided by physician anesthesiologists. Despite being a clear market competitor, the ASA – without solicitation – advanced a position that encouraged lower reimbursement for CRNAs for providing the exact same services to the exact same patients based solely upon their licensure as CRNAs.

ASA has also made efforts at the state level to limit CRNA practice, misconstruing events and spreading false claims related to the safety of anesthesia care provided independently by CRNAs. For example, ASA recently created a one-pager document regarding facility

[28] "Critical Deficiencies at the Washington DC VA Medical Center," (Department of Veterans Affairs, Office of the Inspector General, 2018). https://www.oversight.gov/sites/default/files/oig-reports/VAOIG-17-02644-130.pdf

[29] "Dozens of surgeries at Denver VA hospital put off because of doctor shortage" (David Migoya, 2017). https://www.denverpost.com/2017/10/12/dozens-surgeries-denver-va-hospital-put-off-because-doctor-shortage/

inspection deficiencies at Stanislaus Surgical Hospital and Doctors Medical to claim that the CRNA-only anesthesia care models in California are illegal and risky. This one-pager misrepresented California law and exaggerated CRNA-related risks to promote physician-led care. CRNAs are legally authorized to practice independently in California; this practice is supported by decades of safe practice and research.

Taken as a whole, these lobbying efforts have contributed to the anticompetitive environment in which CRNAs practice. They have in some cases supported government policies that impede independent CRNA practice, and in other cases have impeded government policies that would create a level playing field for CRNAs. In either case, the result has been the same: higher costs and lower competition, inefficient models of anesthesia care delivery, and limited availability of healthcare for consumers and veterans.

Section VII: Restrictive State Laws and Regulations

States are facing increased challenges to ensure patients have appropriate access to care, including anesthesia provider shortages. As a result, many states are modernizing state law to reflect the expertise and skill of CRNAs and other APRNs and to remove bureaucratic and competitive barriers that artificially inhibit care delivery. Specifically, states are reviewing laws and regulations for restrictions on anesthesia care provided by CRNAs.

State law requirements for restrictive physician involvement are antiquated and do not reflect the current nature of anesthesia care. FTC staff have consistently urged state legislators to avoid imposing restrictions on APRN scope of practice unless those restrictions are necessary to address well-founded patient safety concerns.[30] While proponents of state-mandated restrictions – like the AMA and ASA – argue that they increase quality of care, they cite no valid evidence to support this proposition. As noted in *Section II: Peer-Reviewed Evidence Demonstrating CRNA Quality and Safety*, anesthesia care provided independently by CRNAs is just as safe and effective as anesthesia care provided by physician anesthesiologists.

The Tri-Departments additionally found in the 2018 report, "Reforming America's Healthcare System Through Choice and Competition", that, "Extremely rigid collaborative practice agreements and other burdensome forms of physician and dentist supervision are generally not justified by legitimate health and safety concerns. Thus, many states have

[30] Federal Trade Commission. Policy Perspectives: Competition Advocacy and the Regulation of Advanced Practice Nurse Practitioners. Pg. 2. March 2014. https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

granted full practice authority to APRNs, but there is significant room for improvement in other states and for other professions."[31]

Courts have also long recognized the administration of anesthesia by nurses as the practice of nursing. In *Frank v. South*, 194 S.W. 375 (Ky. 1917), the court determined that a nurse administering anesthesia was not engaging in the unauthorized practice of medicine. This court case has not been overturned or contradicted by another court.

In *Montana Society of Anesthesiologists v. Montana Board of Nursing*, 339 Mont. 472, 171 P.3d 704 710-11 (2007), the Supreme Court of Montana reaffirmed this legal principle, recognizing that anesthesia is a specialty within the field of nursing and that nurse anesthetists practice nursing.

In *California Society of Anesthesiologists v. Brown*, 204 Cal. App. 4th 390, 138 Cal. Rptr. 3d 745 (2012), the Court of Appeal of the State of California held that laws relating to the practice of medicine by physicians are not intended to, and therefore do not, limit the scope of practice of other licensed health care professionals, such as CRNAs.

Despite the clear rulings in the courts and the clear evidence for the safety and efficacy of anesthesia care provided independently by CRNAs, states, in addition to the federal government, have placed onerous and unnecessary restrictions on CRNA practice, while groups like the AMA and ASA have lobbied in support of this outdated and anticompetitive practice environment. For example, the Colorado Medical Society and Colorado Society of Anesthesiologists sued Colorado in 2010 when the state decided to opt out of CRNA supervision requirements for certain facilities; the California Medical Association and California Society of Anesthesiologists similarly sued California in 2009 when the state decided to opt out of CRNA supervision requirements.

Table 1: State Restrictions on CRNA Practice in *Appendix: Anticompetitive State Restrictions on CRNA Practice* details some of the unnecessary and anticompetitive state-level restrictions on CRNA practice. In addition to the impacts described above, the patchwork of state-level restrictions has the effect of causing CRNAs to move away from states with overly restrictive requirements, thus exacerbating anesthesia provider shortages in these states.

Section VIII: Conclusion

[31] US Department of Health and Human Services, US Department of the Treasury, and US Department of Labor. Reforming America's Healthcare System Through Choice and Competition. Pg. 35. December 2018. https://home.treasury.gov/system/files/136/Reforming_Americas_Healthcare_System_Through_Choice_and_Competition.pdf

AANA is encouraged that the Trump Administration is making a serious effort to combat anticompetitive regulations. As outlined in this letter, CRNAs face an anticompetitive practice environment on many levels: in the Medicare program, in the Veterans Health Administration, through anticompetitive payment policies issued by commercial health insurance plans, from actions by special interest groups, and at the state level.

The policy solutions proposed by AANA in these comments align with Section 2 of President Trump's Executive Order 14192, "Unleashing Prosperity Through Deregulation",[32] and Section 2 of President Trump's Executive Order 14219, "Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Initiative".[33] Furthermore, these solutions align with the report, "Reforming America's Healthcare System Through Choice and Competition", which the Tri-Departments published during President Trump's first term and which reiterates many of the points raised in this letter regarding the need for greater competition and the safety and efficacy of independently provided APRN – including CRNA – care.[34]

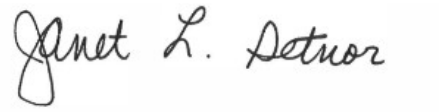
AANA looks forward to collaborating with the Department of Justice to create a level playing field for CRNA practice that will result in lower costs, greater access to healthcare for consumers and veterans, and greater efficiency within the US healthcare system. We specifically ask that the Department of Justice and Federal Trade Commission work with AANA and other federal agencies to remove unnecessary supervision requirements on CRNA practice in the Medicare program, establish CRNA full practice authority within the VHA system, and enforce the provider non-discrimination provision of the Public Health Service Act. We also encourage the Administration to work with State leaders to prioritize the removal of anticompetitive statutes and regulations.

AANA stands ready to assist you in efforts to combat these critical issues and would be honored to meet with you in the coming months to further discuss CRNA practice and our recommended remedies for creating a more competitive CRNA practice landscape. I look forward to this collaboration and to a fruitful working relationship over the next months and years. For any questions or comments, and to schedule a meeting, please do not hesitate

[32] Executive Order 14192. Unleashing Prosperity Through Deregulation. 90 Fed. Reg. 9065 (February 6, 2025). Issued January 31, 2025. https://www.govinfo.gov/content/pkg/FR-2025-02-06/pdf/2025-02345.pdf
[33] Executive Order 14219. Ensuring Lawful Governance and Implementing the President's "Department of Government Efficiency" Deregulatory Agenda. 90 Fed. Reg. 10583 (February 25, 2025). Issued February 19, 2025. https://www.govinfo.gov/content/pkg/FR-2025-02-25/pdf/2025-03138.pdf
[34] US Department of Health and Human Services, US Department of the Treasury, and US Department of Labor. Reforming America's Healthcare System Through Choice and Competition. December 2018. https://home.treasury.gov/system/files/136/Reforming_Americas_Healthcare_System_Through_Choice_and_Competition.pdf

to reach out to Romy Gelb-Zimmer, Director of Regulatory Affairs, at rgelb-zimmer@aana.com.

Sincerely,



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President, AANA

cc: William Bruce, MBA, CAE, AANA Chief Executive Officer
Ingrida Lusis, AANA Chief Advocacy Officer
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Appendix: Anticompetitive State Restrictions on CRNA Practice

Table 1: State Restrictions on CRNA Practice		
State	**Description**	**Citation**
Alabama	Practice as a certified registered nurse anesthetist (CRNA) means the performance of or the assistance in any act involving the determination, preparation, administration, procedural ordering, or monitoring of any drug used to render an individual insensible to pain for surgical and other therapeutic or diagnostic procedures. The nurse anesthetist is qualified in accordance with Section 27-46-3 and is licensed by the Board of Nursing and functions under the direction of or in coordination with a physician licensed to practice medicine, a podiatrist, or a dentist, who is immediately available. Nothing in this paragraph shall be construed to restrict the authority of a health care facility to adopt policies relating to the provision of anesthesia and analgesia services.	NPA, sec. 34-21-81(4)(c)
Arizona	A. A certified registered nurse anesthetist may administer anesthetics under the direction of and in the presence of a physician or surgeon in connection with the preoperative, intraoperative or postoperative care of a patient or as part of a procedure performed by a physician or surgeon in the following settings: 1. A health care institution.	NPA, AZ Rev. Stat., sec. 32-1634.04(A)

	2. An office of a health care professional who is licensed pursuant to chapter 7 [podiatrists], 11 [dentists], 13 [MDs] or 17 [DOs] of this title. 3. An ambulance.	
Connecticut	An advanced practice registered nurse having been issued a license pursuant to section 20-94a shall, for the first three years after having been issued such license, collaborate with a physician licensed to practice medicine in this state [...] [S]uch advanced practice registered nurse licensed pursuant to section 20-94a and maintaining current certification from the American Association of Nurse Anesthetists who is prescribing and administrating medical therapeutics during surgery may only do so if the physician who is medically directing the prescriptive activity is physically present in the institution, clinic or other setting where the surgery is being performed.	NPA, ch. 378, Section 20-87a(b2)
Florida	An advanced practice registered nurse [includes CRNAs] shall perform those functions authorized in this section within the framework of an established protocol which must be maintained on site at the location or locations at which an advanced registered nurse practitioner practices [...] In the case of multiple supervising physicians in the same group, an advanced registered nurse practitioner must enter into a supervisory protocol with at least one physician within the physician group practice. A practitioner currently licensed under chapter 458 [medical doctor], chapter 459 [osteopathic physician], or chapter 466 [dentist] shall maintain supervision for directing the specific course of medical treatment.	NPA, FL Stat., sec. 464.012(3)
Georgia	[...] anesthesia may be administered by a certified registered nurse anesthetist, provided that such anesthesia is administered under the direction and responsibility of a duly licensed physician.	NPA, GA Code, sec. 43-26-11.1
Indiana	A certified registered nurse anesthetist may administer anesthesia if the certified registered nurse anesthetist acts under the direction of and in the immediate presence of a physician.	NPA, IN Code, sec. 25-23-1-30(a)

Kansas	A registered nurse anesthetist shall perform duties and functions in an interdependent role as a member of a physician or dentist directed health care team.	NPA, KS Stat. Ann., sec. 65-1158, subsec. (c)
Louisiana	No registered professional nurse shall administer any form of anesthetic to any person under their care unless the following conditions are met: [...] Administers anesthetics and ancillary services under the direction and supervision of a physician or dentist [...]	NPA, LA Rev. Stat., sec. 37:930, subsec. A(3)
Missouri	Notwithstanding any law to the contrary, a certified registered nurse anesthetist as defined in subdivision (8) of section 335.016, RSMo, shall be permitted to provide anesthesia services without a collaborative practice arrangement provided that he or she is under the supervision of an anesthesiologist or other physician, dentist, or podiatrist who is immediately available if needed [...]	MPA, sec. 334.104(7)
Nevada	Certified registered nurse anesthetist: Authorized practice; prohibited acts. 1. A certified registered nurse anesthetist may: (a) Under the supervision of a physician licensed pursuant to chapter 630 or 633 of NRS, order, prescribe, possess and administer controlled substances, poisons, dangerous drugs and devices to treat a patient under the care of a licensed physician in a critical access hospital in preparation for surgery or childbirth, during surgery or childbirth and while a patient recovers from surgery or childbirth. (b) Possess and administer controlled substances, poisons, dangerous drugs and devices in other circumstances under which a registered nurse is authorized to possess and administer controlled substances, poisons, dangerous drugs and devices. 2. A certified registered nurse anesthetist shall not order or prescribe a controlled substance, poison, dangerous drug or device except as authorized by paragraph (a) of subsection 1. 3. As used in this section, "critical access hospital" means a hospital which has been certified as a critical access hospital by the Secretary of Health and Human Services pursuant to 42 U.S.C. 1395i-4(e).	NPA, NRS 632.2397

Ohio	(B) A nurse authorized to practice as a certified registered nurse anesthetist consistent with the nurse's education and certification and in accordance with rules adopted by the board, may do the following: (1) With supervision and in the immediate presence of a physician, podiatrist, or dentist, administer anesthesia and perform anesthesia induction, maintenance, and emergence; (2) With supervision, obtain informed consent for anesthesia care and perform preanesthetic preparation and evaluation, postanesthetic preparation and evaluation, postanesthesia care, and, subject to section 4723.433 of the Revised Code, clinical support functions; (3) With supervision and in accordance with section 4723.434 of the Revised Code, engage in the activities described in division (A) of that section.	NPA, OH Rev. Code Ann., sec. 4723.43(B)
Oklahoma	§59-650. Interventional pain management license. A. This act shall be known and may be cited as the "Oklahoma Interventional Pain Management and Treatment Act". B. As used in this section: 1. "Chronic pain" means a pain state which is subacute, persistent and intractable; 2. "Fluoroscope" means a radiologic instrument equipped with a fluorescent screen on which opaque internal structures can be viewed as moving shadow images formed by the differential transmission of X-rays throughout the body; and 3. "Interventional pain management" means the practice of medicine devoted to the diagnosis and treatment of chronic pain, through the use of such techniques as: a. ablation of targeted nerves, b. percutaneous precision needle placement within the spinal column with placement of drugs such as local anesthetics,	59 OK Stat § 650

	steroids, analgesics in targeted areas of the spinal column, or c. surgical techniques, such as laser or endoscopic diskectomy, intrathecal infusion pumps and spinal cord stimulators. C. It shall be unlawful to practice or offer to practice interventional pain management in this state unless such person has been duly licensed under the provisions of the Oklahoma Allopathic Medical and Surgical Licensure and Supervision Act or the Oklahoma Osteopathic Medicine Act. D. Nothing in this section shall be construed to forbid the administration of lumbar intra-laminar epidural steroid injections or peripheral nerve blocks by a certified registered nurse anesthetist when requested to do so by a physician and under the supervision of an allopathic or osteopathic physician licensed in this state and under conditions in which timely on-site consultation by such allopathic or osteopathic physician is available. A certified registered nurse anesthetist shall not operate a freestanding pain management facility without direct supervision of a physician who is board-certified in interventional pain management or its equivalent.	
Pennsylvania	Section 8.9. Scope of Practice for Certified Registered Nurse Anesthetists.--(a) A certified registered nurse anesthetist shall have the authority to perform anesthesia services in cooperation with a physician, podiatrist or dentist involved in a procedure for which anesthesia care is being provided if the anesthesia services are performed under the overall direction of any of the following: (1) A physician licensed by the State Board of Medicine or the State Board of Osteopathic Medicine who has completed an accredited residency training program in anesthesiology. (2) A physician licensed by the State Board of Medicine or the State Board of Osteopathic Medicine who is performing the procedure for which the	NPA, sec. 8.8

	certified registered nurse anesthetist is performing anesthesia services. (3) A podiatrist licensed by the State Board of Podiatry who is performing the procedure for which the certified registered nurse anesthetist is performing anesthesia services. (4) A dentist licensed by the State Board of Dentistry and permitted by the act of May 1, 1933 (P.L.216, No.76), known as "The Dental Law" or the State Board of Dentistry to administer, supervise or direct the administration of anesthesia.	
South Carolina	A CRNA must practice in accordance with approved written guidelines developed under supervision of a licensed physician or dentist or approved by the medical staff within the facility where practice privileges have been granted.	NPA, Code of Laws of South Carolina, sec. 40-33-20(20)
Texas	§164.3. Prohibited Acts or Omissions in Advertising *This requires physicians to disclose in their advertising, "supervision of, or delegation to non-physicians at a location that is not the physician's primary practice location."* §177.2. Mandatory Complaint Notification. *This requires physicians to post public notifications on how to file complaints with the board at "any location where physician supervision or delegation is required."* §169.2. General Responsibilities of Delegating Physician. *This requires written protocols and orders to include "a description of the specific instructions, orders, protocols, or procedures to be followed."* §173.2. Standards for Anesthesia Services. *This requires physicians to "comply with delegation and supervision laws under Chapter 157 of the Act, including §157.058, regarding CRNAs."* §169.27. Physician Responsibilities Related to Written Order. *This requires physicians to include in their written orders "a description of appropriate care."*	https://www.tmb.state.tx.us/page/board-rules

Virginia	A certified registered nurse anesthetist shall practice under the supervision of a licensed doctor of medicine, osteopathy, podiatry, or dentistry.	MPA, Code of Virginia, sec. 54.1-2957(C)