HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1381 w/CS Anesthesiologist Assistants
SPONSOR(S): Negron and others
TIED BILLS: None. **IDEN./SIM. BILLS:** SB 2332 (s)

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Health Standards (Sub)	6 Y, 1 N	Rawlins	Collins
2) Health Care	12 Y, 7 N w/CS	Rawlins	Collins
3) Appropriations			
4)			
5)			

SUMMARY ANALYSIS

Health care spending in the United States is projected to reach $2.8 trillion in 2011, up from $1.3 trillion in 2000, according to a report by the Centers for Medicare & Medicaid Services (CMS).

Census data show that employment by non-physician establishments grew by 50 percent, while jobs in hospitals and physician offices increased less than 20 percent between 1987 and 1992.

Licensure laws have the effect of limiting the supply of health care providers and restrict competition to physicians from non-physician practitioners. The primary result is an increase in physician fees and income that drives up health care costs.

The legal authority to provide and be reimbursed for health care services is tied to state statutes generally referred to as practice acts, which establish professional "scopes of practice." These practice acts often differ from state to state and are a source of considerable tension among the professions; resulting in "turf battles" which clog the legislative agenda across the country

Currently, anesthesiologist assistants (AAs) are not licensed to practice in Florida. The only professions currently allowed to assist anesthesiologists in providing care are certified registered nurse anesthetists (CRNAs) regulated under s. 464.012, F.S., and physician assistants (PAs) regulated under chapters 458 and 459, F.S. However, physician assistants may practice in the area of anesthesia only if they meet specified requirements of the boards' rules of having graduated from an approved training program for anesthesia assistants (AAs).

There are currently only two (2) anesthesia trained physician assistants licensed to practice in Florida and there are 2,441 CRNAs licensed to practice in Florida.

At this time, there are two (2) accredited programs for anesthesiologist assistants in the country – Emory University, in Atlanta, Georgia, and Case Western Reserve University, in Cleveland, Ohio. The Commission on
Accreditation of Allied Health Education Programs accredits both of these programs as anesthesiologist assistant programs. These are Master programs and do require an undergraduate degree prior to admission.

This bill creates a new licensed profession, anesthesiologist assistants (AAs), who are licensed and regulated by the Boards of Medicine and Osteopathic Medicine and practice under protocols and direct supervision of Florida licensed anesthesiologists.

According to the Department of Health, revenues will be generated from licensure and application fees for the first fiscal year at approximately $15,250, and the cost to provide the associated regulation is:

- $62,268 in FY 03-04, and
- $53,062 in FY 04-05.

The effective date of the bill is July 1, 2003.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[x]	N/A[]
2. Lower taxes?	Yes[]	No[x]	N/A[]
3. Expand individual freedom?	Yes[x]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[x]
5. Empower families?	Yes[]	No[]	N/A[x]

For any principle that received a "no" above, please explain:

This bill creates a licensure program for a group of health care providers not currently authorized to practice in Florida. The Department of Health anticipates that it will need ½ FTE to implement this program.

B. EFFECT OF PROPOSED CHANGES:

Health care spending in the United States is projected to reach $2.8 trillion in 2011, up from $1.3 trillion in 2000, according to a report by the Centers for Medicare & Medicaid Services (CMS). The CMS report, published March 12, 2002, by the National Health Affairs, projects that for 2001-2011 period, health spending is expected to grow at an average annual rate of 7.3 percent.

According to U.S. Census data, receipts for non-physician providers grew by 83 percent, from $10.3 billion to $18.9 billion, between 1987 and 1992, while physician receipts increased by 56 percent, from $90 billion to $141 billion. Census data show that employment by non-physician establishments grew by 50 percent, while jobs in hospitals and physician offices increased less than 20 percent between 1987 and 1992.[1]

Licensure laws have the effect of limiting the supply of health care providers and restrict competition to physicians from non-physician practitioners. The primary result is an increase in physician fees and income that drives up health care costs.[2]

At a time when government is trying to reduce health spending and improve access to health care, it is imperative to critically examine the extent to which government policies are responsible for rising health costs and the unavailability of health services. It is reported in the Yale Journal on Regulation, that eliminating the roadblocks to competition among health care providers could improve access to health services, lower health costs, and reduce government spending.

Professional licensure laws and other regulatory restrictions impose significant barriers to Americans' freedom of choice in health care. Clark Havighurst, the William Neal Reynolds Professor of Law at Duke University, has pointed out, "Professional licensure laws have long made the provision of most personal health services the exclusive province of physicians. Obviously, such regulation limits consumers' options by forcing them to use highly trained, expensive personnel when other types might serve quite well."[3]

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[1] Cato Policy Analysis No. 246 December 15, 1995, "The Medical Monopoly: Protecting Consumers or Limiting Competition?" Sue A. Blevins.
[2] Ibid.
[3] Clark Havighurst, "The Changing Locus of Decision Making in the Health Care Sector," Journal of Health Politics, Policy, and Law 11 (1986): 700.

Yet the freedom to contract--the right of individuals to decide with whom and for what services they will dispose of their earnings--is one of the fundamental rights of Americans. As Chief Justice John Marshall said in Ogden v. Saunders, "Individuals do not derive from government their right to contract, but bring that right with them into society . . . [e]very man retains [the right] to . . . dispose of [his] property according to his own judgment.

Accordingly, individuals should have the legal right to decide with whom they will contract for the provision and coordination of their health care services: doctors, midwives, nurse practitioners, chiropractors, spiritual healers, or other health care providers.

Health care workforce regulation plays a critical role in consumer protection. For most of this century, the state regulation of health care occupations and professions has established a minimum standard for safe practice and removed the egregiously incompetent. As market and regulatory forces shape the future of health care, particularly the location and content of practice, the structure, and functions of state professional regulation must continue to provide consumers with important protections leading to safe and effective practice.[4]

This ostensible goal of professional regulation – to establish standards that protect consumers from incompetent practitioners – is eclipsed by a tacit goal of protecting the professions' economic prerogatives. This dichotomy of goals has created serious shortcomings that include limited public accountability, and support for practice monopolies that limit access to care and lack of national uniformity.

SCOPES OF PRACTICE AUTHORITY

The legal authority to provide and be reimbursed for health care services is tied to state statutes generally referred to as practice acts, which establish professional "scopes of practice." These practice acts often differ from state to state and are a source of considerable tension among the professions; resulting in "**turf battles"** which clog the legislative agenda across the country. Caught in the middle of these battles, legislators must decide whether new or unregulated disciplines and occupations should be regulated and whether professions currently regulated should be granted expanded practice authority.

ANESTHESIOLOGIST ASSISTANTS

Currently, anesthesiologist assistants are not licensed to practice in Florida. The only professions currently allowed to assist anesthesiologists in providing care are certified registered nurse anesthetists (CRNAs) regulated under s. 464.012, F.S., and physician assistants (PAs) regulated under chapters 458 and 459, F.S. However, physician assistants may practice in the area of anesthesia only if they meet specified requirements of the boards' rules of having graduated from an approved training program for anesthesia assistants (AAs).

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At this time there are two (2) accredited programs for anesthesia assistants in the country – Emory University, in Atlanta, Georgia, and Case Western Reserve University, in Cleveland, Ohio. The Commission on Accreditation of Allied Health Education Programs accredits both of these programs as anesthesiologist assistant programs. These are Master programs and do require an undergraduate degree prior to admission.

[4] See Pew Health Professional Commission report, "Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation," October 1998.

The United States Department of Health and Human Services, Health Care Financing Administration has ruled that anesthesiologist assistants are substantially equivalent to nurse anesthetists for Medicare reimbursement purposes.

The following chart is a brief comparison of the education, training/experience, level of supervision, and type of supervision between non-physician anesthesia providers:

	CRNA	PA/AA*	AA
	Masters Degree (as of 10/01) from CRNA Program, Plus prior RN license	Masters Degree From AA program Plus prior PA license And bachelors degree	Masters Degree from AA Program, Plus bachelors degree
Training/Experience	Clinical Training Usually 1½ to 2 years, Plus RN license	AA Program provides 2 years clinical training as part of anesthesia team, plus PA license	AA Program provides 2 years clinical training as part of anesthesia team
Level of Supervision	General Supervision, as defined by protocol established between CNRA and supervisor	Direct Supervision, as required by rule 64B15-6.010(2)(b)6.	Direct Supervision, as defined in bill: present in office/suite and immediately available to provide assistance and direction
Supervision	Supervisor Licensed MD, DO, DDS	Licensed MD or DO	Licensed MD or DO who has completed anesthesiology training program, and is either board-certified or board-eligible in anesthesiology

* While PAs and AAs are not interchangeable and generally have different scopes of practice, since all PAs in Florida are required to complete an AA training program before assisting in the delivery of anesthesia, the requirements listed on this chart reflect those for a PA wishing to provide anesthesia in Florida, not for a general PA license.

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This bill provides for the regulation of the practice of anesthesiology assistants under the jurisdiction of the Board of Medicine, Board of Osteopathic Medicine, and Council on Physician Assistants. An anesthesiology assistant would be required to practice under the direct supervision of a Florida licensed anesthesiologist.

C. SECTION DIRECTORY:

Section 1. Amends s. 456.048, F.S., requiring anesthesiologist assistants to maintain medical malpractice insurance or provide proof of financial responsibility as a condition of licensure or licensure renewal. The Boards of Medicine and Osteopathic Medicine are required to promulgate rules; excludes PAs and AAs from the other financial responsibility requirements of ss. 458.320 and 459.023, F.S., which requires AAs to meet the same malpractice requirements of chiropractors, acupuncturists, podiatrists and advanced registered nurse practitioners.

Section 2. Amends s. 458.331, F.S., revising grounds for which a physician may be disciplined for failing to provide adequate supervision; and providing penalties.

Section 3. Creates s. 458.3475, F.S., providing definitions as it relates to AA licensure; providing performance standards for anesthesiologist assistants and supervising anesthesiologist assistants; providing for the approval of training programs and for services authorized to be performed by trainees; providing for a task force to study the continued need for licensure and requiring a report; providing for additional powers, and duties of the Board of Medicine and the Board of Osteopathic Medicine for the purposes of promulgating rules for AA licensure standards; providing penalties; providing for disciplinary actions; providing for the adoption of rules; specifying prescribing liability; and providing for the allocation of fees.

Section 4. Amends s. 459.015, F.S., revising grounds for which an Osteopathic physician may be disciplined for failing to adequately supervise the activities of AAs acting under their supervision; and providing penalties.

Section 5. Creates s. 459.023, F.S., providing definitions; providing performance standards for anesthesiologist assistants and supervising anesthesiologist assistants; providing for the approval of training programs and for services authorized to be performed by trainees; providing for a task force to study the continued need for licensure and requiring a report; providing for additional membership, powers, and duties of the Board of Medicine and the Board of Osteopathic Medicine; providing penalties; providing for disciplinary actions; providing for the adoption of rules; specifying prescribing liability; and providing for the allocation of fees.

Section 6. Provides for an effective date of July 1, 2003.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   According to the Department of Health:

	FY 03-04
50 applicants @ 100 (application fee):	$5,000
50 applicants @ $200 (licensure fee)	$10,000
50 applicants @ $5 (unlicensed fee)	$250
Total Revenues:	$15,250

2. Expenditures:

   According to the Department of Health:

   Total Expenses: $62,268

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

This bill would allow anesthesiologist assistants to practice in Florida.

D. FISCAL COMMENTS:

According to the Department of Health, salary and benefits for 2 ½ FTE, was computed using the annual midpoint for pay-band 3 (classification of position) plus 28.67% fringe benefits. This appropriation is not lapsed since a full 12 month funding would be required for implementation preparations.

Revenues were estimated based on an assumption that the boards will impose the same fees as currently provided for Physician Assistants. Revenues for year 1 are based on 50 applicants paying the $100 initial application fee; paying the $200 initial licensure fee; and paying the $5 unlicensed activity fee for a total of $15,250. Revenues for year 2 prorate the initial licensure fee to $100 for 50 applicants for a total of $10,250. Renewals would begin in FY 05-06 and it is assumed that 100 licensees would renew at $200 plus the $5 unlicensed activity fee for a total of $20,500 plus any new revenues from new applicants.

The department may incur additional workload if the regulation of this profession yields an increase in complaint investigations and disciplinary actions.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not require counties or municipalities to spend funds or to take an action requiring the expenditure of funds. This bill does not reduce the percentage of a state tax shared with counties or municipalities. This bill does not reduce the authority that municipalities have to raise revenues.

2. Other:

None.

B. RULE-MAKING AUTHORITY:

The Board of Medicine and the Board of Osteopathic Medicine would need to promulgate rules to implement the licensure provisions set forth in this bill. The bill provides rulemaking authority to each board to promulgate rules necessary to implement each section.

C. DRAFTING ISSUES OR OTHER COMMENTS:

Proponents of this bill have provided committee staff with information supporting the establishment of anesthesiologist assistant regulation in the state of Florida. Proponents assert that regulation will protect the public and will increase the supply of qualified providers of anesthesia. Proponents acknowledge that AAs would compete against CRNAs for positions within anesthesiologist-led anesthesia care teams.

Proponents provided information indicating that 5 states allow AAs to practice through licensure or certification and 7 states allow AAs to practice through physician delegation. Proponents also indicated that proposed legislation or rules are pending in 3 other states to allow AAs to practice.

Opponents of this bill have also provided committee staff with information on how CRNAs and the existing CRNA training programs might be adversely affected by the passage of this legislation. Opponents assert that there are already enough anesthesia training programs in Florida and with the addition of the two newest programs, Florida will have a sufficient supply of anesthesia providers.

Opponents have also asserted that there will be no cost savings to patients as a result of the use of AAs since anesthesia providers are reimbursed at the same rate.

Information provided by the Department of Health indicates that the clinical training varies between CRNAs and AAs/PAs. The department asserts that the anesthesia training for AAs and PAs does not include training in administration of general or regional anesthetic agents.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

On March 27, 2003, the Subcommittee on Health Standards reported the bill favorably to the Health Care Committee with a strike-all amendment. The amendment corrects scrivener's errors in the bill.

On April 15, 2003, the Health Care Committee adopted the amendment recommended by the subcommittee and reported the bill favorably with a committee substitute.