Testimony for the Senate Finance Committee Hearing Strategy: SB 951

To: Members of the Senate Finance Committee

From: Matthew Zinder, DNAP, CRNA

Date: 3/6/26

RE: Opposition regarding the licensing and utilization of Anesthesiologist Assistants (AAs)

Introduction

Good morning members of the Senate Finance Committee. My name is Matthew Zinder, and I am a Certified Registered Nurse Anesthetist (CRNA) with 22 years of experience serving patients in Maryland.

I am here today to address a dangerous misconception: the idea that Anesthesiologist Assistants (AAs) provide an equivalent value to the state's healthcare infrastructure. The reality is that AAs represent a "false equivalency"—they are less qualified than CRNAs, yet they create an unnecessary and redundant financial burden on our facilities and taxpayers.

1. The Experience Deficit

When we discuss patient safety, training and experience is the only currency that matters. A CRNA enters anesthesia training only after obtaining a Bachelor of Science in Nursing and working for 3+ years in high-acuity critical care units. We have managed ventilators, titrated life-saving drips, handled crises, and taken care of critically ill patients long before our first day of anesthesia school.

In contrast, an AA can enter training with any four-year degree and **zero clinical healthcare experience.** We are comparing professionals who have spent years at the bedside to students who may have never touched a patient before their graduate program.

2. Salary Equivalence vs. Redundant Costs

There is no "discount" for the lesser experience of an AA. AAs command salaries equivalent to Nurse Anesthetists and bill for services at the same rates. However, because AAs lack the ability to practice independently, the facility must pay:

1. A full AA salary, **PLUS**
2. The expensive, prorated time of a physician anesthesiologist who must medically direct all aspects of their practice.

This is an unnecessary "utilization cost." A single independent CRNA can do the same work without the redundant overhead of a second provider, saving the state and our hospitals significant resources.

3. The Financial "Acuity Trap"

Proponents of the AA model often point to a 1:4 supervision ratio as a sign of efficiency. This is a mathematical illusion. In high-acuity cases—the very cases where patient safety is most at risk—federal rules require the anesthesiologist to be personally present for key portions of the procedure.

When this happens, the ratio instantly **collapses from 1:4 to 1:1.** At that moment, the cost to the facility effectively doubles for a single patient. This "Acuity Trap" makes the AA model an inefficient and fragile staffing solution for high-stakes surgical environments. It also contributes to Medicare fraud as it is impossible for one anesthesiologist to be in 4 rooms as once. This means it is impossible to fulfil the necessary Medicare regulations for Medical Direction, the model which AA's must practice under.

Closing

In Maryland, we already have the gold standard of care. CRNAs are currently filling the needs of our urban and rural communities alike. We will continue to do so because of our robust schools and our proven independent model. We do not need a more expensive, lesser trained, and a more restricted tier of providers.

I urge this committee to protect our state's fiscal health and patient safety standards by rejecting SB 951.

Thank you,

Matthew Zinder, DNAP, CRNA