



UNITED STATES OF AMERICA  
FEDERAL TRADE COMMISSION  
WASHINGTON, D.C. 20580

Office of Policy Planning  
Bureau of Competition  
Bureau of Economics

March 19, 2013

The Honorable Theresa W. Conroy  
Connecticut State Representative  
105<sup>th</sup> Assembly District  
Legislative Office Building, Room 4113  
Hartford, CT 06106-1591

Dear Representative Conroy:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics<sup>1</sup> appreciate the opportunity to respond to your invitation for comments on the likely competitive impact of Connecticut House Bill 6391 ("the Bill" or "HB6391").<sup>2</sup> Current Connecticut law requires that an Advanced Practice Registered Nurse ("APRN") have a collaborative practice arrangement with a physician before the APRN may offer health care services within his or her established scope of practice. No written agreement is required, unless the APRN will be prescribing medications. The Bill would remove the collaborative practice requirement and allow APRNs to diagnose, treat, and prescribe medications for their patients in accordance with their licensed scope of practice without a collaboration arrangement or agreement with a physician.

Recent reports by the Institute of Medicine ("IOM") have identified a key role for advanced practice nurses in improving the delivery of health care.<sup>3</sup> The IOM, established in 1970 as the health arm of the National Academy of Sciences, provides expert advice to policy makers and the public and has conducted an intensive examination of issues surrounding advanced nursing practice. Among other things, the IOM found that advanced practice nurses play a key role in improving access to health care and that "[r]estrictions on scope of practice . . . have undermined [nurses'] ability to provide and improve both general and advanced care."<sup>4</sup>

Similarly, in December 2012, the National Governors Association (NGA) issued a paper exploring the potential role of APRNs in addressing increased demand for primary care services, particularly in historically underserved areas.<sup>5</sup> The report noted, among its findings and conclusions, that APRNs "may be able to mitigate projected shortages of primary care services [and that e]xisting research suggests that NPs can perform a subset of primary care services as well as or better than physicians."<sup>6</sup>

It is our understanding that the current collaborative practice requirements can be costly to APRNs, assuming they can even find a physician willing to collaborate.<sup>7</sup> As a result, the requirement is likely to increase the price and limit the availability of APRN care. Although overall Connecticut appears to have adequate numbers of primary care providers for current needs,<sup>8</sup> there are shortages in specific areas and for specific populations (*e.g.*, rural and low income patients in urban areas), and shortages are expected to develop or worsen as more Connecticut consumers gain health coverage and seek access to primary health care services.<sup>9</sup> By eliminating the APRN collaboration requirement, the Bill may improve access and consumer choice for primary care services, especially for rural and other underserved populations, and may also encourage beneficial price competition that could help contain health care costs. Of course, FTC staff understand that collaboration between APRNs and other healthcare providers are often beneficial to patients, and are not suggesting that such collaboration should be limited. Rather, staff are suggesting that collaboration does not necessarily require direct supervision by or accountability to another licensed health care provider.<sup>10</sup>

Given the potential benefits of eliminating unwarranted impediments to APRN practice, we recommend that the Connecticut legislature seek to ensure that statutory limits on APRNs are no stricter than patient protection requires. FTC staff do not offer advice on appropriate standards for patient care and safety, but we encourage the legislature to carefully consider available safety evidence on APRN practice in Connecticut and elsewhere. Absent a finding there are countervailing safety concerns regarding APRN practice, HB6391 appears to be a procompetitive improvement in the law that would benefit Connecticut health care consumers.

## **I. INTEREST AND EXPERIENCE OF THE FTC**

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.<sup>11</sup> Competition is at the core of America's economy,<sup>12</sup> and 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. Because of the importance of health care competition to the overall economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,<sup>13</sup> research,<sup>14</sup> and advocacy.<sup>15</sup> Recently, FTC staff have analyzed the likely competitive effects of proposed APRN regulations in other states.<sup>16</sup>

## **II. BACKGROUND: APRN PRACTICE IN CONNECTICUT AND HB6391**

APRNs are licensed by the Connecticut Department of Public Health. According to Connecticut law:

Advanced nursing practice is defined as the performance of advanced level nursing practice activities that, by virtue of post basic specialized education and experience, are appropriate to and may be performed by an advanced practice registered nurse. The advanced practice registered

nurse performs acts of diagnosis and treatment of alterations in health status, as described in subsection (a) of this section, and shall collaborate with a physician licensed to practice medicine in this state. In all settings, the advanced practice registered nurse may, in collaboration with a physician licensed to practice medicine in this state, prescribe, dispense and administer medical therapeutics and corrective measures and may request, sign for, receive and dispense drugs in the form of professional samples in accordance with sections 20-14c to 20-14e.<sup>17</sup>

Connecticut law defines “collaboration” as:

a mutually agreed upon relationship between an advanced practice registered nurse and a physician who is educated, trained or has relevant experience that is related to the work of such advanced practice registered nurse. The collaboration shall address a reasonable and appropriate level of consultation and referral, coverage for the patient in the absence of the advanced practice registered nurse, a method to review patient outcomes and a method of disclosure of the relationship to the patient. Relative to the exercise of prescriptive authority, the collaboration between an advanced practice registered nurse and a physician shall be in writing and shall address the level of schedule II and III controlled substances that the advanced practice registered nurse may prescribe and provide a method to review patient outcomes, including, but not limited to, the review of medical therapeutics, corrective measures, laboratory tests and other diagnostic procedures that the advanced practice registered nurse may prescribe, dispense and administer.<sup>18</sup>

Thus, current law does not require an APRN to have a formal *written* collaborative practice agreement unless the APRN wishes to prescribe medications. Nonetheless, even APRNs who do not choose to prescribe medications must have a physician willing to be identified by name and practice as a collaborator in order to practice to the full extent of their training, education, and abilities. Although collaborative agreements could, in theory, encompass varying arrangements, the IOM Report observes that Connecticut law imposes no requirements for on-site supervision of APRNs, the frequency or extent to which physicians must review the charts of APRN patients, or the maximum number of APRNs with whom a physician may have collaborative arrangements.<sup>19</sup>

### **III. LIKELY COMPETITIVE BENEFITS OF HB6391**

FTC staff recognize that certain professional licensure requirements are necessary to protect patients. Consistent with patient safety, however, we urge legislators to also consider the potential benefits of competition, including improved access to care, lower costs, and increased options, that the passage of HB6391 would likely promote by removing restrictions on APRNs’ ability to practice to the full extent of their training, education, and abilities.

**a. HB6391 Would Likely Improve Access to Primary Care Services**

The United States faces substantial and growing shortages of physicians.<sup>20</sup> While these shortages will exacerbate health care access problems for many American consumers, the impact of reduced access is likely to be most acute among Medicaid beneficiaries, due not only to geographic misalignment between low-income communities and physician practice locations, but also to low physician participation in state Medicaid programs.<sup>21</sup>

Given that APRNs play a key role in filling the gap between demand and supply for health care services, any unnecessary restrictions on APRNs are likely to exacerbate access problems and thereby harm patients. According to one report, the Massachusetts health reform legislation, which mandated health insurance coverage, resulted in “an increase in the wait times for appointments with primary care physicians and an increase in emergency department visits by persons with insurance.”<sup>22</sup> Thus, eliminating unnecessary restrictions on APRNs’ ability to practice may be beneficial for all patients, and especially for those medically underserved areas or populations where there are shortages of primary care providers.

The recent NGA report noted there were 39 federally-designated Health Professional Shortage Areas (“HPSA”) in Connecticut.<sup>23</sup> An estimated 434,885 people in Connecticut live in a Primary Care HSPA.<sup>24</sup> Federal health care reform will expand the number of people with insurance in Connecticut, including approximately 150,000 additional Medicaid enrollees, which is likely to further increase the demand for primary care services, and potentially exacerbate the imbalance between demand for and supply of primary care physicians.<sup>25</sup> Optimizing use of APRNs can mitigate the consequences of current and future shortages of primary care physicians.

APRNs are seen by many as crucial to addressing access problems. As a general matter, APRNs make up a greater share of the primary care workforce in less densely populated, less urban, and lower income areas, as well as in federally-designated HPSAs. APRNs also are more likely than primary care physicians to care for large numbers of minority patients, Medicaid beneficiaries, and uninsured patients.<sup>26</sup> It is also important to note that APRNs are the fastest-growing segment of the primary care professional workforce in the United States. Between the mid-1990s and the mid-2000s, the number of APRNs per capita grew an average of more than nine percent annually, compared with just one percent for primary care physicians.<sup>27</sup> Given that APRNs play a key role in filling the gap between demand and supply for health care services, any unnecessary restrictions on APRNs are likely to exacerbate access problems and thereby harm some of the most vulnerable patients.<sup>28</sup> In Connecticut there are approximately 2,526 licensed APRNs, and it is estimated that approximately 1,667 practice in primary care settings.<sup>29</sup> Some reports suggest more APRNs practice in states that allow independent practice (i.e., practice without immediate supervision or collaborative agreement requirements).<sup>30</sup> Thus, if Connecticut eliminates the requirement for a collaborative agreement for full

practice authority for APRNs, Connecticut may benefit from a growth in the number of APRNs.

In sum, the Bill's elimination of the collaborative practice agreement requirement for APRNs may improve access and consumer choice for primary care services, especially for rural and other underserved populations.

**b. HB6391 Would Likely Lower Costs and Increase Consumer Options**

HB6391, which would remove the requirement that APRNs have a collaborative agreement with a physician, also is likely to reduce the cost of basic health care services and could spur innovation in health care delivery and broaden the range of choices available to consumers. APRN care is generally less expensive to patients and payers than physician care, and is often provided in a variety of health care delivery settings.<sup>31</sup> Similar to the situation in other states, there is anecdotal evidence suggesting some Connecticut APRNs who wish to set up a practice that is separate from a physician or other health care entity (*e.g.*, they are not employees) must pay physicians to enter a collaborative agreement.<sup>32</sup> Unless these arrangements involve true and beneficial supervision,<sup>33</sup> they raise the possibility that APRNs are *not* compensating physicians for their time, but rather for the potential loss of income some physicians believe may occur as a result of APRNs' entry into the primary care marketplace. Such payments raise the costs of practice, likely resulting in fewer independently practicing APRNs and higher prices, without any improvement in the quality of care provided.

The Connecticut Coalition of Nurse Practitioners, in a formal request for review and expansion of APRNs' scope of practice made to the Department of Public Health, provided five specific case examples of APRNs' difficulties in identifying physicians willing to collaborate.<sup>34</sup> These case examples illustrate several issues of concern. First, securing a collaborative practice agreement may be a difficult process for some APRNs. Some APRNs who attempted to use the Connecticut State Medical Society's "APRN Assist" link to find a physician collaborator did not receive any response or were told there were no physicians "hiring" at that time, even though the APRN explained she was not looking for a job, but for a collaborator.<sup>35</sup> Second, APRNs may find it difficult and costly to develop a sustainable business with this requirement in place. Even if they find a physician who is able and willing to agree to collaborative practice, the APRN may not be able to find a substitute if a collaborating physician retires, relocates, passes away, or just decides to revoke or refuse to renew the collaborative practice agreement.<sup>36</sup> Finally, the case examples suggested one APRN had to pay a collaborating physician 70 percent of her reimbursement and another APRN had to pay \$30,000 per year to the collaborating physician.<sup>37</sup>

APRNs have also played an important role in the development of alternative settings for care delivery, such as retail clinics. Retail clinics typically are located within larger retail stores, staffed by APRNs, and offer consumers a convenient way to obtain basic medical care at competitive prices.<sup>38</sup> Retail clinics generally offer weekend and evening hours, which provide greater flexibility for patients,<sup>39</sup> and appear to provide

competitive incentives for other types of physician practices to offer extended hours as well.<sup>40</sup> Elimination by the Connecticut legislature of the requirement that APRNs collaborate with a physician might increase both the number and types of care settings available to Connecticut consumers.<sup>41</sup>

**c. Legislative Consideration of Health and Safety Issues**

As previously noted, certain professional licensure requirements are necessary to protect patients. It is unclear, however, whether the current Connecticut collaboration requirement provides any additional patient protection.<sup>42</sup> Moreover, the IOM, based on an extensive review of the studies and literature on the safety of APRNs as primary care providers, has recommended that nurses be permitted by state licensing laws to practice to the full extent of their education and training.<sup>43</sup> The IOM noted some “states have kept pace with the evolution of the health care system by changing their scope-of-practice regulations to allow NPs to see patients and prescribe medications without a physician’s supervision or collaboration,” and that sixteen states and the District of Columbia allow APRNs to practice and prescribe independently.<sup>44</sup> The IOM further stated that “[n]o studies suggest that care is better in states that have more restrictive scope-of-practice regulations for APRNs than in those that do not.”<sup>45</sup>

Similarly, the National Governors Association stated that it “performed an up-to-date review of peer-reviewed literature relevant to NP scope of practice policy [and] focused primarily on research that compares health care offered by NPs (working either solo or in teams with physicians) to health care offered exclusively by physicians.”<sup>46</sup> The NGA’s review concluded: “None of the studies in NGA’s literature review raise concerns about the quality of care offered by NPs. Most studies showed that NP-provided care is comparable to physician-provided care on several process and outcome measures. Moreover, the studies suggest that NPs may provide improved access to care.”<sup>47</sup> The report also noted that in order to “better meet the nation’s current and growing need for primary care providers, states may want to consider easing their scope of practice restrictions and modifying their reimbursement policies to encourage greater NP involvement in the provision of primary care.”<sup>48</sup>

We further note that HB6391 does not otherwise change either the scope of APRN practice or established regulatory oversight of APRNs in Connecticut, nor does it limit institutional credentialing, or other aspects of collaboration or oversight established by hospitals, ambulatory care facilities, or other clinics in the state.

**IV. CONCLUSION**

HB6391 would remove the requirement that APRNs enter into collaborative practice agreements with physicians, permitting them to fully employ their education and experience in serving Connecticut health care consumers in accordance with state licensure standards. Removing this requirement has the potential to benefit consumers by expanding choices for patients, containing costs, and improving access. Accordingly, we encourage legislators to consider whether the existing requirement is necessary to assure patient safety in light of your own regulatory experience and the expert findings of the

IOM, as well as the literature review and conclusions of the National Governors Association. Maintaining an unnecessary and burdensome requirement is likely to deprive consumers of the benefits that increased competition can provide. Therefore, the Connecticut legislature should carefully consider the safety record of APRNs in Connecticut. Absent countervailing safety concerns regarding APRN practice, HB6391 appears to be a procompetitive improvement in the law that would benefit Connecticut health care consumers.

Respectfully submitted,

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

<sup>2</sup> Letter from the Hon. Theresa W. Conroy, Connecticut House of Representatives, to Andrew I. Gavil, Director, Office of Policy Planning, Federal Trade Commission (rec'd Feb. 7, 2013) [hereinafter Letter from Rep. Conroy].

<sup>3</sup> See generally INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH (2011) [hereinafter IOM NURSING REPORT] (especially Summary, 1-15).

<sup>4</sup> *Id.* at 4. See also *id.* at 85-161, 98-99 (discussing nursing scope-of-practice issues and quality of care, including numerous quality of care studies); About the Institute of Medicine, available at <http://www.iom.edu/About-IOM.aspx>.

<sup>5</sup> National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (Dec. 20, 2012), at: <http://www.nga.org/cms/home/nga-center-for-best-practices/center->

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[divisions/page-health-division/col2-content/list--health-left/list-health-highlight/content-reference-2@/the-role-of-nurse-practitioners.html](#) [hereinafter NGA, *Role of Nurse Practitioners*].

<sup>6</sup> *Id.* at 11.

<sup>7</sup> See Request from the Connecticut APRN Coalition for Consideration of Scope of Practice Change Submitted to the Connecticut Department of Public Health (Aug. 10, 2012), at: [http://www.ct.gov/dph/lib/dph/practitioner\\_licensing\\_and\\_investigations/2013\\_scope\\_of\\_practice/ct\\_aprn\\_coalition\\_scope\\_of\\_practice\\_request.pdf](http://www.ct.gov/dph/lib/dph/practitioner_licensing_and_investigations/2013_scope_of_practice/ct_aprn_coalition_scope_of_practice_request.pdf) (providing specific examples of APRNs who have had difficulty finding physicians with whom to collaborate or finding one willing to collaborate for a reasonable fee) [hereinafter, “CT APRN Coalition’s Request for Scope of Practice Change”]. According to the Department of Public Health’s website, at: [http://www.ct.gov/dph/cwp/view.asp?a=3121&q=486562&PM=1&dphNav=|&dphNav\\_GID=1821](http://www.ct.gov/dph/cwp/view.asp?a=3121&q=486562&PM=1&dphNav=|&dphNav_GID=1821):

Connecticut Public Act 11-209, *An Act Concerning the Department of Public Health's Oversight Responsibilities Relating to Scope of Practice Determinations for Healthcare Professions*, establishes a process for the submission and review of requests from health care professions seeking to revise or establish a scope of practice prior to consideration by the General Assembly. Under the provisions of this act, scope of practice review committees may review and evaluate these requests and provide findings to the joint standing committee of the General Assembly having cognizance of matters relating to public health. The Department of Public Health (DPH) is responsible for receiving requests and for establishing and providing support to the review committees, within available appropriations.

<sup>8</sup> See, e.g., Univ. of CT, Center for Public Health and Health Policy Report, *Assessment of Primary Care Capacity in Connecticut* (Dec. 2008), at: [http://publichealth.uconn.edu/images/reports/PrimaryCare\\_Report\\_02\\_17\\_09.pdf](http://publichealth.uconn.edu/images/reports/PrimaryCare_Report_02_17_09.pdf) (indicating that although overall capacity appears adequate for current needs, there are shortage areas, especially in rural areas and for low income patients in large cities) [hereinafter Univ. of CT, *Assessment of Primary Care Capacity*]; U.S. Dep’t Health & Human Servs., Health Resources & Servs. Admin., Find Shortage Areas: MUA/P by State and County, available at <http://muafind.hrsa.gov/index.aspx> (last checked Mar. 1, 2013) (indicating shortage areas in Connecticut, especially in rural areas and for low income patients in large cities by HRSA criteria).

<sup>9</sup> See, e.g., Univ. of CT, *Assessment of Primary Care Capacity*, *supra* note 8 at ii (noting “while Connecticut may be able to absorb near term increases in primary care services demand without any improvements in primary care capacity and workforce policy, this may not be the case in the future”); *id.* at 3 (discussing increased wait times for appointments with primary care providers after Massachusetts’ enacted health care reform).

<sup>10</sup> See P. Mitchell, et al., DISCUSSION PAPER, INSTITUTE OF MEDICINE, *Core Principles & Values of Effective Team-Based Health Care* (Oct. 2012) at <http://www.iom.edu/tbc>. [Hereinafter IOM, *Team-Based Health Care*].

<sup>11</sup> Federal Trade Commission Act, 15 U.S.C. § 45.

<sup>12</sup> *Standard Oil Co. v. Fed. Tr. Comm’n*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

<sup>13</sup> See FTC, *An Overview of FTC Antitrust Actions in Health Care Services and Products* (Mar. 2013), available at <http://www.ftc.gov/bc/healthcare/antitrust/hcupdate.pdf>; FTC, *Competition in the Health Care Marketplace: Formal Commission Actions (1996 – 2008)*, available at <http://www.ftc.gov/bc/healthcare/antitrust/commissionactions.htm>.

<sup>14</sup> See FTC & U.S. DEP’T OF JUSTICE (“DOJ”), *IMPROVING HEALTH CARE: A DOSE OF COMPETITION* (2004), available at <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf> [hereinafter FTC & DOJ, *IMPROVING HEALTH CARE*].



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<sup>15</sup> FTC and staff advocacy 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. Timothy Burns, Connecticut Legislature, (May 1, 2009) (regarding proposed restrictions on mobile dentistry), *available at* <http://www.ftc.gov/os/2009/05/V090009Connecticutdentistry.pdf>; FTC and DOJ 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, IMPROVING HEALTH CARE *supra* note 14.

<sup>16</sup> FTC Staff Testimony Before Subcommittee A of the Joint Committee on Health of the State of West Virginia Legislature on The Review of West Virginia Laws Governing the Scope of Practice for Advanced Practice Registered Nurses and Consideration of Possible Revisions to Remove Practice Restrictions (Sept. 2012), *available at* <http://www.ftc.gov/os/2012/09/120907wvatestimony.pdf>; FTC Staff Letter to The Hon. Thomas P. Willmott and The Hon. Patrick C. Williams, Louisiana House of Representatives, Concerning the Likely Competitive Impact of Louisiana House Bill 951 Concerning Advanced Practice Registered Nurses (Apr. 2012), *available at* <http://www.ftc.gov/os/2012/04/120425louisianastaffcomment.pdf>; FTC Staff Letter to The Hon. Paul Hornback, Senator, Commonwealth of Kentucky State Senate Concerning Kentucky Senate Bill 187 and the Regulation of Advanced Practice Registered Nurses (Mar. 2012), *available at* [http://www.ftc.gov/os/2012/03/120326ky\\_staffletter.pdf](http://www.ftc.gov/os/2012/03/120326ky_staffletter.pdf); FTC Staff Letter to The Hon. Rodney Ellis and The Hon. Royce West, the Senate of the State of Texas, Concerning Texas Senate Bills 1260 and 1339 and the Regulation of Advanced Practice Registered Nurses (May 2011), *available at* <http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf>; FTC Staff Letter to The Hon. Daphne Campbell, Florida House of Representatives, Concerning Florida House Bill 4103 and the Regulation of Advanced Registered Nurse Practitioners (Mar. 2011), *available at* <http://www.ftc.gov/os/2011/03/V110004campbell-florida.pdf>.

<sup>17</sup> CONN. GEN. STAT. § 20-87a (2012). The Connecticut Department of Public Health is responsible for issuing licenses to nurses, CONN. GEN. STAT. § 20-92 (2012) and to APRNs, CONN. GEN. STAT. § 20-94 (2012). The Connecticut State Board of Examiners for Nursing consults with the Department of Health concerning licensure examinations for licensed practical nurses and registered nurses. CONN. GEN. STAT. § 20-90a (2012). In addition, “the [nursing] board shall (1) hear and decide matters concerning suspension or revocation of licensure, (2) adjudicate complaints filed against practitioners licensed under this chapter and impose sanctions where appropriate.” CONN. GEN. STAT. § 20-90b (2012). CONN. GEN. STAT. § 20-94a (2012) states:

The Department of Public Health may issue an advanced practice registered nurse license to a person seeking to perform the activities described in subsection (b) of section 20-87a, upon receipt of a fee of two hundred dollars, to an applicant who: (1) Maintains a license as a registered nurse in this state, as provided by section 20-93 or 20-94; (2) holds and maintains current certification as a nurse practitioner, a clinical nurse specialist or a nurse anesthetist from one of the following national certifying bodies that certify nurses in advanced practice: The American Nurses' Association, the Nurses' Association of the American College of Obstetricians and Gynecologists Certification Corporation, the National Board of Pediatric Nurse Practitioners and Associates or the American Association of Nurse Anesthetists, their successors or other appropriate national certifying bodies approved by the Board of Examiners for Nursing; (3) has completed thirty hours of education in pharmacology for advanced nursing practice; and (4) if first certified by one of the foregoing certifying bodies after December 31, 1994, holds a master's degree in nursing or in a related field recognized for certification as either a nurse practitioner, a clinical nurse specialist, or a nurse anesthetist by one of the foregoing certifying bodies.

<sup>18</sup> CONN. GEN. STAT. § 20-87a (2012). It is our understanding under current law that although an APRN must have a collaboration agreement with a physician in order to practice independently, the agreement must only be in writing if the APRN will be prescribing medications.

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<sup>19</sup> IOM FUTURE OF NURSING REPORT, *supra* note 3, at 157, Table 3-A1. See also IOM, *Team-Based Health Care*, *supra* note 10 at 11-12 (discussing the elements of effective team-based health care and noting issues concerning scope-of-practice and independent practice appear much less problematic in the field than in the political arena).

<sup>20</sup> See Kaiser Commission on Medicaid and the Uninsured, *Improving Access to Adult Primary Care in Medicaid: Exploring the Potential Role of Nurse Practitioners and Physician Assistants*, at 1 (Mar. 2011), available at <http://www.kff.org/medicaid/upload/8167.pdf> [hereinafter “Kaiser Commission, *Improving Access*”]; the Association of American Medical Colleges (AAMC) Physician Shortages Factsheet, available at [https://www.aamc.org/download/150584/data/physician\\_shortages\\_factsheet.pdf](https://www.aamc.org/download/150584/data/physician_shortages_factsheet.pdf) (in its projections of physician supply and demand, the AAMC assumes that each additional two NPs (or Physicians Assistants) reduce physician demand by one) [hereinafter “AAMC, *Physician Shortages*”]; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES, HEALTH RESOURCES AND SERVICES ADMINISTRATION BUREAU OF HEALTH PROFESSIONS, THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND, 70-72, exhibits 51-52 (2008), available at <http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf>. [Hereinafter HRSA PHYSICIAN WORKFORCE REPORT].

<sup>21</sup> See Kaiser Commission, *Improving Access*, *supra* note 20, at 1.

<sup>22</sup> Univ. of CT, *Assessment of Primary Care Capacity*, *supra* note 8, at 3. See also discussion concerning APRNs and retail clinics, *infra* at Section III.b.

<sup>23</sup> NGA, *Role of Nurse Practitioners*, *supra* note 5. See also Kaiser Family Foundation, statehealthfacts.org, Primary Care Health Professional Shortage Areas (HPSAs), available at [http://www.statehealthfacts.org/comparemapreport.jsp?rep=112&cat=8&utm\\_source=shfonl&utm\\_medium=email&utm\\_campaign=040512short](http://www.statehealthfacts.org/comparemapreport.jsp?rep=112&cat=8&utm_source=shfonl&utm_medium=email&utm_campaign=040512short) (indicating 12.2% of Connecticut population living in HPSA) (last checked Mar. 4, 2013). For a general description of HPSAs, see U.S. Dep’t Health and Human Servs., HRSA, Guidelines for Primary Medical Care/Dental HPSA Designation, <http://bhpr.hrsa.gov/shortage/hpsas/designationcriteria/medicaldentalhpsaguidelines.html> (last checked Mar. 4, 2013).

<sup>24</sup> Kaiser Family Foundation, statehealthfacts.org, Primary Care Health Professional Shortage Areas (HPSAs), available at [http://www.statehealthfacts.org/comparemapreport.jsp?rep=112&cat=8&utm\\_source=shfonl&utm\\_medium=email&utm\\_campaign=040512short](http://www.statehealthfacts.org/comparemapreport.jsp?rep=112&cat=8&utm_source=shfonl&utm_medium=email&utm_campaign=040512short) (last checked Mar. 4, 2013).

<sup>25</sup> See Kaiser Commission on Medicaid and the Uninsured, *The Cost and Coverage Implications of the ACA Medicaid Expansion: National and State-by-State Analysis*, at 48, Table 9, (Nov. 2012), available at: <http://www.kff.org/medicaid/upload/8384.pdf>.

<sup>26</sup> Kaiser Commission, *Improving Access*, *supra* note 20, at 3.

<sup>27</sup> See Kaiser Commission, *Improving Access*, *supra* note 20, at 3; AAMC, *Physician Shortages*, *supra* note 20.

<sup>28</sup> See generally AARP & Robert Wood Johnson Foundation, Center to Champion Nursing in America, *Access to Care and Advanced Practice Nurses: A Review of Southern U.S. Practice Laws* (2010), available at <http://championnursing.org/resources/access-care-and-advanced-practice-nurses-review-southern-us-practice-laws> (policy paper discussing restrictions on APRN practice in 11 southern states, including the impact on access and consumers and advocating the removal of state restrictions on APRNs’ practice, including the removal of restrictions on prescriptive authority). See also discussion *supra* at note 19 and accompanying text.

<sup>29</sup> Univ. of CT, *Assessment of Primary Care Capacity*, *supra* note 8 at 7.

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<sup>30</sup> See, e.g., TEXAS LEGISLATIVE BUDGET BOARD STAFF, TEXAS STATE GOVERNMENT EFFECTIVENESS AND EFFICIENCY: SELECTED ISSUES AND RECOMMENDATIONS 297, 300 (Jan. 2011) (submitted to the 82<sup>nd</sup> Texas Legislature) (indicating that 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”) [hereinafter TEXAS BUDGET BOARD STAFF REPORT]; Julie A. Fairman et al., *Perspective: Broadening the Scope of Nursing Practice*, 364 N. ENGL. J. MED. 193, 194 (2011) (noting “nurses tend to move from more restrictive to less restrictive states . . . with a resulting loss of access to care for patients”).

<sup>31</sup> See Joanne M. Pohl et al., *Unleashing Nurse Practitioners’ Potential to Deliver Primary Care and Lead Teams*, 29 HEALTH AFFAIRS 900, 901 (2010), available at <http://content.healthaffairs.org/content/29/5/900.full.pdf+html> (noting APRNs and physicians assistants are underutilized “despite being qualified to provide primary care at a lower cost than other providers”).

<sup>32</sup> See CT APRN Coalition’s Request for Scope of Practice Change, *supra* note 7 at 8. Anecdotal evidence from other states suggests APRNs pay significant fees to collaborating physicians. See, e.g., Letter from The Hon. Paul Hornback, Commonwealth of Kentucky State Senate, to Susan DeSanti, Director, Office of Policy Planning, Federal Trade Commission (Jan. 18, 2012) (noting in “some cases, the physicians are charging a considerable amount of money monthly or annually to sign a CAPA [the collaborative prescribing agreement], although they essentially perform no services for the fee”); Letter from The Hon. Thomas P. Willmott and The Hon. Patrick C. Williams, Louisiana House of Representatives, to Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission (Jan. 18, 2012), (noting that APRNs in Louisiana often must pay 10-45% of their collected fees to physicians for entering into collaborative practice agreements).

<sup>33</sup> See discussion in Section II *supra* at note 19 and accompanying text.

<sup>34</sup> CT APRN Coalition’s Request for Scope of Practice Change, *supra* note 7 at 8.

<sup>35</sup> *Id.* at 8 (Case #1 and Case #2).

<sup>36</sup> See *Id.* (Case #1).

<sup>37</sup> *Id.* (Case #4 and Case #5); see also *supra* note 32 and citations therein.

<sup>38</sup> See Robin Weinick, et al., *Policy Implications of the Use of Retail Clinics* at 12 (2010) (Rand Health Technical Report prepared for the U.S. Dept. of Health and Human Serv.), at [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2010/RAND\\_TR810.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR810.pdf) [hereinafter Rand, *Policy Implications of the Use of Retail Clinics*] (also noting the services offered at retail clinics are generally narrower in scope than those provided by urgent care centers and emergency rooms); Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients Visits*, 27 HEALTH AFFAIRS 1272, 1279 (2008). 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 retail clinics); 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>.

Evidence indicates 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) (analyzing 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”).

<sup>39</sup> 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

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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.”).

<sup>40</sup> See Robin Weinick, et al., *Policy Implications of the Use of Retail Clinics* at 12 (2010) (Rand Health Technical Report prepared for the U.S. Dept. of Health and Human Serv.), at [http://www.rand.org/content/dam/rand/pubs/technical\\_reports/2010/RAND\\_TR810.pdf](http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR810.pdf) (according to many medical community representatives interviewed for this report, including a representative of the American Medical Association, “retail clinics have stimulated physicians to adopt evening and weekend hours”).

<sup>41</sup> See, e.g., TEXAS BUDGET BOARD STAFF REPORT, *supra* note 30, at 300 (noting restrictions on APRNs’ scope of practice may limit both the number and types of retail clinics available to Texas consumers); MARY TAKACH & KATHY WITGERT, NATIONAL ACADEMY FOR STATE HEALTH POLICY, ANALYSIS OF STATE REGULATIONS AND POLICIES GOVERNING THE OPERATION AND LICENSURE OF RETAIL CLINICS 6 (Feb. 2009) (noting “the most powerful state regulatory tools affecting [retail clinics’] operations are the scope of practice regulations that govern nurse practitioners and other non-physician medical personnel”).

<sup>42</sup> See discussion in Section II *supra* at note 19 and accompanying text.

<sup>43</sup> IOM NURSING REPORT, *supra* note 5 at 85-161; see especially *id.* at 98 (with respect to many primary care services, “the contention that APRNs are less able than physicians to deliver care that is safe, effective, and efficient is not supported by the decades of research that has examined this question”) (internal citations omitted).

<sup>44</sup> *Id.* at 98.

<sup>45</sup> *Id.* at 99. See also Julie A. Fairman et al., *Perspective: Broadening the Scope of Nursing Practice*, 364 N. ENGL. J. MED. 193, 194 (2011) (stating “[t]here are no data to suggest that nurse practitioners in states that impose greater restrictions on their practice provide safer and better care than those in less restrictive states or that the role of the physician has changed or deteriorated”).

<sup>46</sup> NGA, *Role of Nurse Practitioners*, *supra* note 5 at 5.

<sup>47</sup> *Id.* at 7-8; see also *id.* at 1 (noting “[r]esearch suggests that NPs can perform many primary care services as well as physicians do and achieve equal or higher patient satisfaction rates among their patients”).

<sup>48</sup> *Id.* at 1; see also *id.* at 11.