"I am a student at Columbia University. However, this comment to the Federal Trade Commission reflects my own personal opinions. This is not representative of the views of Columbia University or the Trustees of Columbia University."

Memorandum

RE: Discontinuity in State Regulations Hinder Retail Clinics

DATE: 25 April 2014

Executive Summary

This memo provides information on the growth of retail clinics in the United States. *Using evidence gathered from literature searches, a problem of state-level regulations creating discontinuities in retail clinic operations is defined*. Three policy options are presented to address the problem: have the FTC make formal recommendation for services to be provided at retail clinics for states to use as a guideline, have the FTC recommend the removal of scope-of-practice regulations on nurse practitioners, or transfer the jurisdiction of healthcare licensure from the states to the federal government. Ultimately proposed is that the FTC should recommend nurse practitioner autonomy and the removal of scope-of-practice laws.

Background

Retail clinics provide care for simple acute illnesses as well as preventative care. They are located in various retail settings, including in pharmacies, grocery stores and "big box" chains. The first retail clinic opened in Minnesota in 2000. By 2010, an estimated 1260 retail clinics were in operation, with the number expected to expand to 5000 by 2015 (Spetz, 2013; Tu, 2013). Since their entry to the market, retail clinics have often been cited by many as a positive development in healthcare, and are viewed as being able to provide speedy and affordable care. In 2007, there were 1.48 million visits to retail clinics nationwide and by 2009, that number climbed to 5.97 million (Mehrotra, 2012). While the public's utilization of retail clinics has been low, it is anticipated that their use will continue to rise in the coming years.

An estimated that 90% of all retail clinic visits are comprised of the following acute care and preventative services: upper respiratory infections, bronchitis, pharyngitis, sinusitis, otis media, otis externa, conjunctivitis, urinary tract infections, immunizations, and simple laboratory tests. In contrast, these ten services account for only 18% of primary care visits and 12% of emergency department visits (Mehrotra, 2008). This suggests that retail clinics are fulfilling specific needs of the public and have the potential to shift some patient care away from physicians and emergency departments.

Utilization of retail clinics is influenced by several factors. Individuals going to retail clinics tend to be 18 to 45 years old, and are less likely to have a designated primary care doctor (Mehrotra, 2008). People visiting retail clinics have also been found to be less likely to have health insurance, but it is unclear if that trend will continue with the passage of the PPACA. Consumers choosing to go to retail clinics cite several factors for making their decision, including walk-in services, convenient locations, low cost, and no usual source of primary care (Tu, 2013). An estimated 45% of visits to retail clinics are during the weekend or weekday hours when primary care practices are typically closed (Spetz, 2013). The average cost of a retail clinic visit ranges from $60 to $80. Most retail clinics accept private insurance (97%), Medicare (93%), and Medicaid (60%) (Tu, 2013). This suggests that retail clinics primary competitive advantages over tradition sources of care due to both their convenience and their cost.

The potential cost-saving ability of retail clinics has been widely discussed in healthcare as a potential disruptive innovation (Hwang, 2013). With high demand for primary care physicians and limited supply, many have called for the redesign of primary care (Berwick 2008; Bohmer, 2009). Retail clinics are one proposed solution, as they shift some of the reliance away from primary care physicians and emergency departments. Retail clinics cost approximately $50 less per visit than a primary care visit, and hundreds of dollars less than an emergency department visit (Mehrotra, 2008). An estimated 13.7 to 27.1% of all emergency department visits are capable of being handled by retail clinics and urgent care centers, with an estimated savings of $2

to $7 billion dollars a year (Weinick, 2010; RAND 2010). This ability to cut healthcare costs is an important avenue to explore.

Retail clinics are able to offer cheaper care through their use of nurse practitioners (NPs) and physician assistants (PAs) as staff. NPs are certified nurses that have had received additional graduate-level training. An NP's level of autonomy in practice varies on a state-by-state basis due to scope-of-practice regulations determined at the state level. Twenty-two states and the District of Columbia allow nurse practitioners full autonomy (Spetz, 2013). However, other states require NPs have practice oversight by physicians. Scope-of-practice regulations limit the ability of NPs to work independently and have also been shown to limit the growth of retail clinics (Spetz, 2013; RAND, 2010). These regulations have been justified by arguing that they protect quality of care. However, studies have found no statistically significant differences in the quality of care provided by physicians versus NPs (Mehrotra 2009; Spetz, 2013; Wang, 2010). These regulations also require retail clinics to hire physicians, which increase their operating costs and can reduce the potential for clinics to offer healthcare savings. Many physician associations support NP oversight. An unintended consequence of scope-of-practice regulations has been slow growth of retail clinics in states with these regulations.

Retail clinics also face several criticisms. Many physician associations cite concerns around the potential for fragmented care and inappropriate treatment of disease (Mehrotra, 2009; Spetz, 2013; Thygeson, 2008). By 2011, 16 states had considered legislation addressing retail clinics, and Massachusetts passed strict regulations specifying the services that can be provided (Deloitte, 2009; RAND, 2010). Nonetheless, the range of services provided at retail clinic is expanding to include the management of chronic diseases. The expansion of services is, in part, due to a growing trend of partnerships forming between retail clinics and hospitals (Deloitte, 2009; Mehrotra, 2012; RAND, 2010).

Evidence

Data for this paper was gathered by performing literature searches in Google Scholar to find information about retail clinics pertaining to services provided, consumer utilization, quality of care, regulations, and market developments. Articles were compiled and reviewed. Information gathered was utilized in the development of the conclusions presented in this paper.

Problem

Retail clinics provide convenient, affordable healthcare. However, several barriers exist that prevent their full potential from being actualized. Due to state-specific guidelines for their operation, as well as scope-of-practice regulations of nurse practitioners, retail clinics have to adjust their operating operations on a state-by-state basis, creating discontinuity and potentially reducing their ability to offer healthcare savings. Given that the number of retail clinics will continue to rise, and that American's use of retail clinics will also increase, it is important to address the discontinuities in retail clinics due to state regulations.

Policy Options

Option 1: Draft formal recommendations for the services provided at retail clinics. Retail clinics are currently expanding the services they offer to include care for more complex health issues, such as the treatment of chronic conditions. In order to encourage continuity across the country, the FTC should create a formal recommendation for the types of services to be provided at retail clinics. Retail clinics have been shown to offer cheaper care for the services they have traditionally provided, however it is unclear of their effectiveness in managing more complicated care. A formal recommendation should encourage retail clinics to continue their treatment of simple acute illness and preventative services, but propose that additional research be done to determine if they have the capacity to deliver more complex healthcare services.

Option 2: Encourage states to remove scope-of-practice regulations that currently restrict nurse practitioners' autonomous practice. Scope-of-practice regulations are argued to be important tools

for ensuring quality of care. Yet, studies have proven that the care provided by nurse practitioners is of equivalent quality to the care provided by physicians. Because physician reimbursements are higher than nurse practitioner reimbursements, scope-of-practice regulations raise the overall costs of healthcare. The state-by-state variation also makes it difficult for retail clinic companies to create standard operating procedures, which can also increase the costs of operating clinics in states where physician oversight is required. Because scope-of-practice regulations occur on a state-by-state basis, a formal recommendation by the FTC would also require a summary of studies that have shown the benefit of increasing nurse practitioner autonomy.

Option 3: Move the licensure of healthcare providers under federal jurisdiction. Currently, licensure of healthcare providers occurs at the state level. However, this has created a fragmented system in which there is a great deal of state-by-state variation in regulations relating to healthcare. In turn, this can lead to unnecessary and inconsistent healthcare expenditures. In a time of healthcare reform that aims to expand coverage and reduce overall healthcare costs, removing licensure of healthcare providers from state jurisdiction and placing it in the federal level is a compelling option. However, the feasibility of doing so is low, as it would require significant government intervention and likely meet strong resistance from states.

Recommendation

A formal recommendation by the FTC to encourage states with restrictive scope-of-practice regulations for nurse practitioners to allow them full practice autonomy is the best option, as it would benefit retail clinics and other healthcare settings. At present, 22 states and the District of Columbia allow full nurse practitioner autonomy, while the remaining states require varying levels of physician oversight. These restrictions hinder the expansion of retail clinics and prevent nurse practitioners from practicing to their highest level of knowledge, as is recommended by the Institute of Medicine (Spetz, 2013). Allowing full autonomy of nurse

practitioners will enable retail clinics to continue their expansion into more parts of the country, and provide more citizens with affordable healthcare options.

However, many physician associations oppose proposals allowing for nurse practitioner autonomy. From an economic standpoint, it can be argued that physician resistance may be a form of rent-seeking behavior. Studies have shown that, in states with scope-of-practice regulations, nurse practitioner salaries are reduced by 14% and physician salaries increase by 6% (Kleiner, 2014). Considering that studies have not found lower quality of care, it is important to examine the motivation behind laws that limit scope-of-practice.

Moving forward, it is proposed that the FTC do the following: draft formal recommendation calling on states with scope-of-practice regulations on nurse practitioners to allow them to practice autonomously. The FTC should also compile evidence to support this recommendation in the form of a report. Evidence to support nurse practitioner autonomy can include healthcare cost reductions, comparable quality of care to physicians, and other pertinent information.

With the passage of the Patient Protection and Affordable Care Act, an increased demand for care will be placed on physicians, and it may not be possible to continue with a physician-centric model of care for simple acute illnesses. Retail clinics are one innovation that can address issues relating both to unmet needs of patients and healthcare spending in the United States. Because the ability of retail clinics to expand and operate at optimum levels is tied to the ability of nurse practitioners to practice without physician oversight, it is critical that state regulations be loosened.

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