



April 30, 2014

Donald S. Clark
Secretary
Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue NW
Washington, DC 20580

Re: FTC Healthcare Workshop, Project No. P131207

Dear Mr. Clark:

On behalf of the American Association of Colleges of Nursing (AACN), we respectfully submit the following comments regarding the notice of the Federal Trade Commission's (FTC) public workshop, *Examining Health Care Competition*. AACN represents over 740 schools of nursing nationwide that educate approximately 450,000 students and employ over 17,000 faculty members. Collectively, these institutions produce approximately half of our nation's registered nurses and all nurse faculty, Advanced Practice Registered Nurses (APRNs- including Nurse Practitioners (NPs), Certified Registered Nurse Anesthetists (CRNAs), Certified Nurse-Midwives, and Clinical Nurse Specialists), and nurse scientists.

AACN commends the FTC's leadership in organizing the public workshop on March 20-21, 2014 that examined healthcare competition in relation to professional regulation of healthcare providers; innovations in healthcare delivery; measuring and assessing quality of care; and price transparency of healthcare services. The FTC's measured and analytical approach to these important topics comes at a time when all healthcare stakeholders are invested in quality, outcome-driven policy changes for America's patients. This requires that a critical lens be focused on state and federal policies that limit healthy competition which, in turn, compromises innovation in the marketplace; impedes access to the full range of healthcare clinicians qualified to provide a wide spectrum of services; and can ultimately increase cost within the delivery system.

A clear direction must be set so that healthcare consumers are not restricted from selecting their preferred healthcare provider due to anticompetitive laws and regulations. Many of these are outdated considering the rapidly changing healthcare system and the way in which consumers expect their care to be delivered. Moreover, the degree to which these policies adhere to the current body of evidence in the literature needs to be examined.

AACN has closely followed the FTC's work to thoughtfully review state legislation that would impact healthcare trade practices of APRNs and appreciates the FTC's most recent work, *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*. Therefore, we plan to specifically comment on the professional regulation of healthcare providers.

ADVANCING HIGHER EDUCATION IN NURSING

Professional Regulation of Healthcare Providers

AACN's mission is to serve the public interest by setting standards, providing resources, and developing the leadership capacity of member schools to advance nursing education, research, and practice. Our vision for the future is that highly-educated and diverse nursing professionals will lead the delivery of quality health care and the generation of new knowledge to improve health and the delivery of care services. This mission and vision, which is consistent with other national nursing organizations, can only be achieved if APRNs are able to practice to the full extent of their education and training.

Our member institutions provide APRN students with the knowledge base and expertise necessary to meet the demands of our nation's primary and acute care needs. This educational infrastructure prepares APRNs to independently conduct patient evaluations, diagnose common conditions, order and interpret diagnostic tests, initiate and monitor treatments, and write prescriptions. APRNs receive extensive clinical training to ensure they are prepared to make quality diagnoses in an efficient manner that ensures patient safety and often saves the healthcare system critical time, money, and resources.

APRN graduates must pass a national certification examination to demonstrate their knowledge and competency. These exams provide a rigorous test of an APRN's skill set. To maintain the certification, APRNs must demonstrate continued professional or educational development, as well as complete a minimum number of practice hours between license renewals.ⁱ

AACN, nursing accrediting agencies, and certifying bodies regulate the educational standards and practice parameters of APRNs. Therefore, APRN scope of practice is determined by the profession and subject to state legislation and regulation through nurse practice acts as well as state healthcare facility licensing statutes and regulations. However, as the FTC has noted, the current laws and regulations in many states inhibit APRNs from practicing to the full extent of their education and training, resulting in anticompetitive policies.

The supporters of these policies often cite a lack of educational preparation by APRNs to safely care for patients across the country. This argument can be effectively refuted by the decades of evidence that show APRN care is safe and of high quality. In 1987, the Federal Office of Technology Assessment conducted a meta-analysis of the quality and safety of care delivered by nurse practitioners, physician assistants, and certified nurse-midwives. The overwhelming conclusion of that analysis was that these clinicians are highly-skilled, knowledgeable, and effective providers of care. This study also concluded that a significant portion of the care needs of this country could be delivered by these clinicians.ⁱⁱ Five years later, the *Yale Journal on Regulation* (1992) reported, "the evidence to date confirms the cost-effectiveness of these providers [NPs], given the diversity of the populations they serve, often as substitutes for physicians." It was also noted that care by APRNs produces equivalent patient outcomes to other providers given their patients' better compliance to care regimens. Moreover, there are lower costs associated with educating APRNs, and the article noted there was increased patient satisfaction with APRN care.ⁱⁱⁱ Over the next decade, numerous studies were published documenting the critical role APRNs play in providing cost-effective and high-quality care. The most recent meta-analysis, in 2011, documented quality patient outcomes related to APRN care delivery.^{iv}

The position that APRNs should be able to practice to the full extent of their education and training is not one held solely by national nursing organizations, but also by other highly regarded entities such

as the Macy Foundation^v, National Governors Association^{vi}, AARP^{vii}, and most notably, the Institute of Medicine (IOM)^{viii}. The IOM is a non-government agency that develops authoritative, evidence-based recommendations on national healthcare issues. In one of its most recent reports, *The Future of Nursing: Leading Change, Advancing Health*, its first key message to policy makers and the public is that “nurses should practice to the full extent of their education and training.” The first recommendation under this key message is that “scope of practice barriers should be removed.” The report clearly documents that the educational standards and years of research serve as rationale for why APRNs should be able to practice independently. Many states currently have no supervisory requirements for APRN practice.^{ix}

Policies at the state or federal level that impose restrictions on APRN practice affect continuity of care, cost, staffing decisions, and access. In fact, a recent article in *Health Affairs* demonstrated the impact of removing these restrictions for nurse practitioners. Kuo et al. (2013) assessed care provided by NPs in the U.S. in relation to state scope of practice regulations using a national sample of 5% of Medicare beneficiaries. They found that Medicare patients who received care from NPs increased fifteen-fold between 1998 and 2010. Medicare patients in states with more relaxed NP scope of practice regulations were 2.5 times more likely to receive their care from an NP than in states with strict NP regulations. The authors conclude that reducing NP state regulations would increase the use of NPs, and thereby decrease the shortage of primary care providers.^x For CRNAs, Hogan et al. (2010) examined the literature on anesthesia patient safety, finding that anesthesia by CRNAs, anesthesiologists, or both together was increasingly safe, and that the model of nonmedically directed CRNA services was the most cost-effective delivery model.^{xi}

Additionally, considering cost, a 2013 study by Spetz and colleagues sought to determine whether or not scope of practice laws limited cost savings for retail clinics. Their findings reported that care received from APRNs was linked with lower total costs when compared with care received from urgent care clinics, physician offices, and emergency departments. When APRNs were permitted to practice independently in retail clinics, the cost savings were even greater than in those where they were not permitted to practice independently.^{xii}

In some remote and underserved areas, APRNs are the only provider within miles. Odell, Kippenbrock, Buron, and Narcisse (2013) administered a survey to 479 APRNs in the Lower Mississippi River Delta region (Arkansas, Louisiana, Mississippi, and Tennessee) to understand the characteristics of those who practice in this region, the supply of healthcare workers, and the possibility that APRNs would practice in these regions. The majority (51%) practiced in primary care, 24% practiced in a Health Professional Shortage Area (HPSA), and 54% practiced in a rural setting. It was noted that Family Nurse Practitioners were more likely to practice in HPSAs and rural communities than their counterparts. The authors concluded that efforts to expand scope of practice would allow NPs to practice autonomously, thereby increasing access to care in rural and underserved regions.^{xiii}

As millions of Americans begin to access the healthcare system through the newly established Health Insurance Marketplace, the nation must prepare for the dual demand: services and providers. Currently, 71,791 nursing students are studying to become graduate-prepared APRNs.^{xiv} This number is the high-water mark for the continually rising trend in APRN student enrollment. Between academic years 2011-2012 and 2012-2013, enrollments increased by 10.4%. The following academic year, enrollment grew by 14.8%. This equates to an additional 15,182 new students in just two academic years.

These graduates will enter into practice in states where they are considered full practice providers, and in other states where their practice is restricted by scope of practice laws and regulations that require physician oversight. APRNs are a solution to the primary and acute care shortages and will continue to be so in the future. Given the impending influx of healthcare consumers, AACN firmly believes that both state and federal laws and regulations that inhibit healthcare competition must be removed.

AACN encourages the FTC to continue their efforts to protect the public through critical analysis of barriers to fair trade healthcare practices. Should you have any questions or require further information, please contact AACN's Director of Government Affairs and Health Policy, Dr. Suzanne Miyamoto, at smiyamoto@aacn.nche.edu or 202-463-6930, ext. 247.

Sincerely,

Eileen T. Breslin PhD, RN, FAAN
President

ⁱ American Nurses Credentialing Center. (2012). Certification Program. Silver Spring, MD. Retrieved from: http://208.49.13.43/ANCC_POD/UserContentStart.aspx?pl=Certification+Overview+Brochure

ⁱⁱ U.S. Congress, Office of Technology Assessment. (December 1986). *Health Technology Case Study 37: Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis [OTA STUDY]*, Publication No. OTA-HCS-37, p. 39. Washington, DC: U.S. Government Printing Office.

ⁱⁱⁱ Safriet, & Barbara J., "Health Care Dollars and Regulatory Sense: The Role of Advanced Practice Nursing," *Yale Journal on Regulation*, Summer 1992, pp. 426-440.

^{iv} Robin P. Newhouse et al., (2011). Advanced Practice Nurse Outcomes 1990-2008: A Systematic Review. *Nursing Economics* 29(5).

^v Cronenwett, L., & Dzau, V. (2010). Who will provide primary care and how will they be trained? *Josiah Macy, Jr. Foundation*.

^{vi} National Governors Association. (2012). The role of nurse practitioners in meeting increasing demand for primary care. Retrieved from: <http://www.nga.org/cms/home/nga-center-for-best-practices/center-publications/page-health-publications/col2-content/main-content-list/the-role-of-nurse-practitioners.html>

^{vii} Brassard, A., Smolenski, M. (2011). Removing barriers to advanced practice registered nurse care: Hospital privileges. *AARP Public Policy Institute: Insight on the Issues*. Retrieved from: <http://www.aarp.org/health/doctors-hospitals/info-10-2011/Removing-Barriers-to-Advanced-Practice-Registered-Nurse-Care-Hospital-Privileges.html>

^{viii} Institute of Medicine. (2011). *The Future of Nursing: Leading Change, Advancing Health*. National Academies Press.

^{ix} National Council of State Boards of Nursing (2014). APRNs in the U.S.: APRN Maps. Retrieved from: <https://www.ncsbn.org/2567.htm>

^x Kuo, Y.F., Loresto, F.L., Rounds, L.R., Goodwin, J.S. (2013). States with the least restrictive regulations experienced the largest increase in patients seen by nurse practitioners. *Health Affairs*. 32(7), 1236-1243.

^{xi} Paul F. Hogan et. al, "Cost Effectiveness Analysis of Anesthesia Providers." *Nursing Economic*. 2010; 28:159-169. Available at: http://www.aana.com/advocacy/federalgovernmentaffairs/Documents/nec_mj_10_hogan.pdf.

^{xii} Spetz, J., Parente, S., Town, R., Bazarko, D. (2013). Scope-of-practice laws for nurse practitioners limit cost savings that can be achieved in retail clinics. *Health Affairs*. 32(11), 1977-1984.

^{xiii} Odell, E., Kippenbrock, T., Buron, W., Narcisse, MR. (2013). Gaps in the primary care of rural and underserved populations: The impact of nurse practitioners in four Mississippi Delta states. *Journal of the American Association of Nurse Practitioners*. 25, 659-666.

^{xiv} American Association of Colleges of Nursing. (2014). *2013-2014 Enrollment and Graduations in Baccalaureate and Graduate Programs in Nursing*. Washington, DC.