AMERICAN NURSES ASSOCIATION

TESTIMONY BEFORE THE

FEDERAL TRADE COMMISSION AND DEPARTMENT OF JUSTICE

ON

PERSPECTIVES ON COMPETITION POLICY AND THE HEALTH CARE MARKETPLACE

FEBRUARY 27, 2003

Thank you for the opportunity to testify today at the Public Hearings on "Perspectives on Competition Policy and the Health Care Marketplace." ANA represents the interests of the nation's 2.7 million registered nurses through 54 constituent member state and territorial associations and over 150,000 members. ANA also has 13 nursing organizational affiliates collectively representing several hundred thousand additional nurses. On behalf of these nurses, and specifically, advanced practice registered nurses ("APRNs"), I am presenting this testimony.

Evolving over thirty-five years ago, this category of practitioners which includes nurse practitioners, nurse midwives, nurse anesthetists and clinical nurse specialists, have been prepared at the masters level to provide various levels of primary and specialized care. In lieu of making references to all categories of APRN, I will use the terms APRN or nurse practitioner ("NP")[1]. Those who created the role envisioned the evolution of a clinician who could work

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[1]Since most advanced practice nurses are identified as nurse practitioners in state licensure laws or through the professional certification process, I will use the generic term "nurse practitioner"("NP") to discuss issues surrounding advanced practice nursing.

independently or in collaboration with physicians and other healthcare providers. Early definitions characterized NPs' role as providing primary health care in a variety of settings.[2] Early on, many NPs were denied hospital-nursing privileges, and the evolution of a nursing role was not consistently welcomed within nursing. Since the development of this role, NPs have sought recognition both within and outside of nursing. However, the definition and scope of NP practice have evolved toward more independent clinical decision making. The American Academy of Nurse Practitioners (AANP) now defines NPs as unique in the constellation of APNs, functioning independently and collaboratively like APNs but active in a broad array of specialties and settings and managing both medical and nursing problems.[3] The American College of Nurse Practitioners (ACNP) defines the NP role in relation to physicians: "A nurse

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[2] Robert L. Phillips Jr., Doreen C. Harper, Mary Wakefield, Larry A. Green, and George E. Fryer Jr., "Can Nurse Practitioners And Physicians Beat Parochialism Into Plowshares?; A collaborative, integrated health care workforce could improve patient care", *Health Affairs* (September, 2002 - October, 2002).

[3] American Academy of Nurse Practitioners, Nurse Practitioner as an Advanced Practice Nurse: Role Position Statement (Austin: AANP, 2000).

practitioner provides some care previously offered only by physicians while working in collaboration with physicians." [4]

With licensure and statutory recognition of nurse practitioner practice, many in nursing believed that the new profession would gain acceptance and the ability to practice as primary care providers. Today, all states recognize nurse practitioners and advanced practice registered nurses through legislation or regulation.[5] And, all but one of the 50 states have authorized nurse practitioners to prescribe.[6] Thirteen states allow nurse practitioners to prescribe controlled substances without physician involvement. An additional 32 states allow nurse practitioners to prescribe controlled substances with some physician involvement.[7] At least 12 states recognize

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[4] American College of Nurse Practitioners, "What Is a Nurse Practitioner?" November 2001, www.nurse. org/acnp/facts/whatis.shtml (10 February 2002).

[5]See Attachment A, STATE LEGISLATION WHICH AFFECTS NURSING PRACTICE, American Nurses Association (1999).

[6]See Attachment B, Fifteenth Annual Legislative Update: How Each State Stands on Legislative Issues Affecting Advanced Nursing Practice, Linda Pearson, *Nurse Practitioner*, vol. 28, no.1 (January 2003)

[7] Ibid.

nurses as primary care providers[8] and another 12 states have antidiscrimination laws to protect nurse practitioner practice and mandate nondiscrimination in privileging and credentialing[9]. However, nurse practitioners continually run up against legislative, private and public barriers to independent practice and the growth of the profession.

THE STRUCTURE OF STATE LICENSURE LEGISLATION AND REGULATION HAS BEEN USED TO CONTROL THE GROWTH AND THE INDEPENDENCE OF NURSE PRACTITIONER PRACTICE.

Concerned about the perceptions of physicians, the nursing community when creating the nurse practitioner role debated potential structures of advanced practice legislation and decided to advocate for a structure that would statutorily mandate collaborative practice. Thus, 24 states incorporate references to relationships with other providers into the advanced practice statutes or regulations. Although all health care professionals collaborate, medical associations, pharmaceutical companies, managed care entities and insurers have attempted to turn collaboration provisions into mandated supervision requirements. And, in doing so, they have created an infrastructure which makes it imperative that NPs have access to consultative and referral networks of physicians. The Catch-22 between collaboration and physician support has

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[8]See Attachment C, REFERENCES TO NURSES AS PRIMARY CARE PROVIDERS IN STATE STATUE, American Nurses Association (January 2003).

[9]See Attachment D, STATES WHICH OFFER PRIVILEGING, American Nurses Association (2001).

created an infrastructure which makes independent practice for APRNs extremely cumbersome and economically unfeasible.

Other laws have been structured to counteract the provisions of nursing licensure laws. A classic example of changes in law designed to undermine the ability of nurses to practice independently have been provisions added into medical licensure laws to limit the number of collaborative arrangements between nurses and physicians. Also, provisions have been added to medical practice acts to discipline physicians for failure to properly supervise APRNs[10]. And, provisions have been added to medical and nursing practice acts to create advisory boards or committees to oversee advanced practice regulation.[11] These laws have been used to forestall promulgation of regulations to facilitate advanced practice; or alternatively to force promulgation of regulations to mandate supervision, after state legislatures have reviewed and voted not to impose such requirements.

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[10]See the Alabama code, which reads "The board shall provide for penalties for violation of rules and regulations promulgated by the board, including the revocation or suspension of approval of registration to act as an assistant to a physician and approval of physicians to supervise assistants to physicians." Code of Ala. @ 34-24-293 (2002).

[11]See Chart E, Joint Regulation of Advanced Practice, American Nurses Association, April 1997.

Some laws have been enacted to promote alternative arrangements to increase the market strength of physicians. Physician collective bargaining bills fall into this category. The ANA has worked with states to oppose this legislation, in part, because allowing physicians to collectively bargain typically minimizes the ability of nurse practitioners and advanced practice registered nurses to obtain arrangements to practice independently. Also, with physician collective bargaining, NP/APRNs are usually blocked out of the collective bargaining group and have no protections against the activities of the larger, physician-dominated unit. This legislation ultimately undermines competition between nurse practitioners and physicians.

Any willing provider laws have been used to equalize the market, then challenged or interpreted to give disproportionate power to existing market forces. Originally designed to ensure that any licensed healthcare provider authorized to provide the service would be allowed to contract with managed care providers, the any willing provider laws have been interpreted, restructured and interpreted over again, to: 1) cover only physician practice; 2) allow the managed care company to choose the providers, as to do otherwise, would grant inappropriate interference into business decisionmaking; or 3) negate the provisions, as the state laws have been held to violate ERISA. A case is currently before the Supreme Court to address concerns created by these types of laws.

Kentucky Association of Health Plans v. Miller[12] involves an "any willing provider'' law requiring HMOs to open their network to any provider that agrees to the provider contract. The

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[12]Case number 00-1471, argued January 14, 2003.

justices asked why plans believe such laws violate the federal Employee Retirement Income Security Act. ERISA does not allow states to regulate employee benefits but permits state regulation of insurance. The state of Kentucky argued that the mandate indeed regulates insurance by prohibiting insurers from arbitrarily limiting providers and by giving patients greater choice and control. Managed care companies argue that the 1994 law is among the broader of the so-called "any willing provider" laws requiring health plans to open closed networks; that the law would apply to all health care professionals and would increase administrative costs, thus making it harder for HMOs to monitor quality. We believe equitable application of the law would reduce consumer costs, and enhance equitable competition among health professionals.

MARKET IMPERFECTIONS WHICH HINDER NURSE PRACTITIONER PRACTICE.

Additionally, the environment around health care reimbursement has created serious impediments to NP/APRN practice. Insurance companies and the government use payment codes based on a medical model of care and designed by non-governmental organizations, which continue to own and control the coding process. Such ownership and control of the existing reimbursement codes by non-governmental entities, combined with the widespread healthcare infrastructure that supports such use of these codes, creates an unfair disadvantage for any non-physician practitioner.

The payment and coding process is the backbone of any healthcare organization or entity – one is paid based solely on the codes. Originally, the coding was designed to address physician practice only and was later expanded to cover nonphysician practice. Fiscal intermediaries, companies that contract with the government, review and process claims and often have problems determining appropriate application of reimbursement codes for NP/APRN. Thus, the fiscal intermediary determines if the skill sets of the nurse practitioner allow him/her to take the proper steps related to the diagnostic code used. If the fiscal intermediary does not believe that the nurse is competent to work at the skill level required of the code, that coding is denied and the nurse must bill at a lesser code (for a lower reimbursement).

Coding challenges are cumbersome, complex and time consuming, and decisions tend to favor the fiscal intermediary. In the past, the fiscal intermediary could create an additional set of codes specific to its reimbursement responsibilities, which was applicable only to the care processed through that fiscal intermediary. In doing so, inconsistencies occurred in the interpretation of the primary and the extrapolated code. Nurse practitioners with businesses have to gingerly address the minefield of coding, without comprehensive direction or guidance from coding manuals or the government. Although nurse coding experts exist, one often gets conflicting advice from the experts. This is an important concern in the existing health care environment where all health practitioners and providers fear inappropriate coding, government audit and potential assessment of fines. Further, with the enforcement of the Health Insurance Portability and Accountability Act (HIPAA) and the standardization of the reimbursement and other electronic transactions through the HIPAA regulations, the additional intermediary-specific

codes that were designed to address perceived deficits or inconsistencies in the reimbursement codes have been eliminated. Thus, the reimbursement infrastructure for nurse practitioners has little uniformity. Only those who are willing to tread on unknown territory, knowing that they might not get any reimbursement strike out at independent practice or bill independently. There is some certainty and support for uniformity in reimbursement policies in physician practice – there isn't with NP/APRN practice.

Additionally, the process for development and valuation of codes begs for change. Nurses and other nonphysician providers sit on advisory committees, and make recommendations to the full committee of physicians; however, the advisory committees do not have full participation in the coding process. In short, the process limits the ability of non-physician providers to have full participation in the code development process. This ultimately impacts the ability of nurse practitioners to effectively obtain payment for services from all healthcare reimbursement sources.

Likewise, the Medicare certification process also impedes the ability of nurse practitioners to practice independently. The primary Medicare certification organization – the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") – treats nurse practitioners and other nonphysician providers as licensed independent providers ("LIP"). Though nurse practitioners are allowed to practice and prescribe independently in many states, this group of practitioners is lumped with other practitioners who are required by law and certification to practice in a supervised structure. The JCAHO standards mandate physician review of care and treatment

plans of LIP and further require physician supervision of “complex care”. This standard obviates the nurse practitioner-patient relationship by forcing the nurse practitioner to introduce another practitioner into the relationship, regardless of the need for additional review or the patient’s desires. Further, these JCAHO standards add to the cost of care. The patient is required to pay for his/her practitioner and the services of a physician. Moreover, the nurse practitioner has to explain why this third party is mandated to intervene in the hospital setting, when such intervention may not be required in the clinical setting. In short the requirement creates a market balanced toward protecting the economic interests of physicians.[13]

In addition to restrictive reimbursement policies, nurse practitioners often have other problems with health insurers. Specifically, health insurers and managed care providers are reticent about placing nurses on provider panels or alternatively, once the provider has been placed on a panel, the nurse may find him/herself removed arbitrarily, by no fault of their own. Even with the history of licensure and national certification of nurse practitioners, nurse practitioners cannot rely on acceptance though institutional credentialing. Often, the NP encounters physician peer review committees which are not designed to evaluate nurse practitioner practice; or supervisory requirements for credentialing (although state law allows for NP independent practice). Some institutions hire NPs as employees and treat them as physician extenders. Other institutions or insurers create a “credentialing” process for NP employees. And, seldom, if ever, are

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[13]ANA expressed its concerns to the JCAHO about the Licensed Independent Provider standards in comments dated March 17, 1995 (Attachment F).

nonphysician practitioners allowed to sit on committees for bylaw development and seldom are nonphysician practitioners given full voting privileges. The reality is that hospital and health care credentialing of nurse practitioners seldom provides the benefits or support system granted to physicians. To place perspectives on market imperfections, I would like to share with you the e-mail of a nurse practitioner that I received on February 6th . It clearly reflects the environment in which nurse practitioners have to fight to provide care. The e-mail reads as follows:

> "This has been a discourag[ing] week in my practice. I am the sole provider in a rural clinic. . . . .On Friday, my Blue Cross provider relations person dropped off the new provider directories. My name, and those of every NP and CNM, had been deleted. When I asked why this occurred, I was told that BCBS no longer contracted with NPs for their services. BCBS also administers several other plans and our names were deleted from those directories as well.
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> "All of my claims since Jan. 1 are being denied. I was told to bill under my collaborating doc. He doesn't see patients here. In essence, he is our employee and is paid for his collaborative role. His billing and mine are completely separate.
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> "Today I was notified by my billing clerk that yet another insurance product is claiming that I am out of network. My pay source is unusual for a rural health clinic – I have been 40% private insurance, 35% Medicaid, 15% out of pocket and 10% Medicare. This turn of events will be very damaging to this clinic.
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> "I also feel that NPs are targets of discrimination in this case. By not listing the NPs we cannot be identified for new business. My frustration is growing by leaps and bounds."

Blue Cross/Blue Shield is not the only provider that has refused to empanel or recredential nurse practitioners.[14] Just as this e-mail vividly articulates market imperfections and anticompetitive behavior, nurse practitioners throughout the country have shared similar stories. In some instances, the nurse practitioner moved from one state to another with the belief he/she would be able to obtain credentials with the same corporate entity after the move, only to find that within the new region or state, the company did not empanel nurse practitioners.

By letter dated October 7, 2002, we articulated problems and concerns of nurse practitioners related to acceptance of prescriptions by pharmaceutical benefit managers and internet pharmacies. We will not repeat our discussion of that issue in this testimony, but believe that the conduct of pharmaceutical companies, pharmaceutical benefit managers and mail order pharmacies not only create additional market imperfections, but also increase the costs of drugs for the nurse practitioner client. Thus, the market as well as the treatment of the nurse within that market is anticompetitive and begs governmental review.

MARKET IMPERFECTIONS FORESTALL AND OFTEN BLOCK THE CREATION OF NURSE PRACTITIONER BUSINESSES.

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[14]See June 1997 letter to United Healthcare from ANA about problems with credentialing and prescriptive practice of clinical nurse specialists. United Healthcare ultimately worked with the ANA to address nurse practitioner credentialing issues. (Attachment G)

These market imperfections create such imbalance within the market that physicians use the imperfections to control nurse practitioner entry. Specifically, physicians can do so in the following manner:

$ Refusal to Collaborate – Physicians can refuse to collaborate without justification and nurse practitioners have no recourse. State laws do not require due process or indicate penalties for failure to collaborate. Throughout the country, physicians have formally or informally banded together to refuse to collaborate, thus driving nurse practitioners out of that clinic.

$ Insurance Companies Policies and Procedures – Insurance companies have developed policies and procedures related to coding, credentialing and care, which have ultimately limited or blocked nurse practitioner practice. State nurses associations have attempted to investigate such claims and seek state attorney generals to investigate the claims. However, none has taken on the task, in part because of the difficulties in proving deliberate, collusive conduct.

$ Mandated inclusion of nurses on physician insurance policies/insurance surcharges – A number of states require nurses who collaborate or who are supervised by physicians to purchase insurance jointly with the physician provider. This mandate, by law or policy, places the nurse practitioner in a risk market inconsistent with her practice and drives up the cost of NP insurance. Likewise, some physician insurers impose surcharges on physicians who collaborate, which are inconsistent with the low

malpractice rates of nurse practitioners[15]. By doing so, the physician who collaborates has a disincentive to use a nurse practitioner or to pay a nurse practitioner equitably for services rendered.

The foundation for nurse practitioner practice is described as rocky at best. Without government intervention, organizations and businesses will continue to use their institutional power to retain the status quo, regardless of the efficacy and desirability of nurse practitioner practice. We believe that if the market imperfections were addressed and consumers were given a clear, unfettered option, independent nurse practitioner practice would grow and evolve. We ask for support to address the outdated infrastructure and for support for balanced market competition.

In addition to these comments the American Nurses Association will submit additional comments expanding on the issues and concerns presented today throughout the year to reflect our ongoing interest in the FTC/DOJ hearings on these most important issues.

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[15] To date, the only formal action taken on surcharges by an insurance commissioner has been In the Matter of National Capital Reciprocal Insurance Company 1991 Rate Filing. In this action, the physician-owned reciprocal insurance company contended they needed to add a surcharge on all physicians in collaborative relationships with nurse midwives, because there was added risk of lawsuits. The District of Columbia Insurance Commissioner found the rate increase was based solely on the "judgement" of a physician board, which reviewed rates, thus the rates were not justified through relevant data. The Superintendent also held that the insurer could not impose a vicarious liability surcharge unless it could support a rate increase with statistical data. The insurance company could not.

Thank you for your time and attention.