



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

Office of Policy Planning
Bureau of Competition
Bureau of Economics

April 20, 2012

The Hon. Thomas P. Willmott
Louisiana State Representative
District 92
2002 20th Street, Suite 204-A
Kenner, LA 70062

The Hon. Patrick C. Williams
Louisiana State Representative
District 4
1500 N. Market St., Suite A-200
Shreveport, LA 71107

Dear Representatives Willmott and Williams:

The staffs of the Federal Trade Commission’s Office of Policy Planning, Bureau of Competition, and Bureau of Economics¹ appreciate the opportunity to respond to your invitation for comments on the likely competitive impact of Louisiana House Bill 951 (“the Bill” or “HB951”).² As you note, current Louisiana law generally requires that an Advanced Practice Registered Nurse (“APRN”) must have a formal written collaborative practice agreement with a physician before the APRN may offer health care services within his or her established scope of practice. You have suggested that “this requirement reduces health care access and choices for Louisiana residents.”³ To address those concerns, the Bill would remove the collaborative practice requirement for APRNs who practice in medically underserved areas or treat medically underserved populations.

Recent reports by the Institute of Medicine (“IOM”) have identified a key role for advanced practice nurses in improving the delivery of health care.⁴ 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.”⁵

You have advised that the currently required collaborative practice agreement can be extremely costly to APRNs.⁶ As a result, the requirement is likely to increase the price and limit the availability of APRN care. Louisiana currently suffers from shortages of primary care providers,⁷ and these shortages are expected to worsen as more Louisiana consumers gain health insurance and seek access to primary health care services.⁸ The Bill's elimination of the collaborative practice agreement requirement for APRNs serving medically underserved areas or patient populations 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.

Given the potential benefits of eliminating unwarranted impediments to APRN practice, we recommend that the Louisiana 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 Louisiana and elsewhere. Absent a finding there are countervailing safety concerns regarding APRN practice, HB951 appears to be a procompetitive improvement in the law that would benefit Louisiana 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.⁹ Competition is at the core of America's economy,¹⁰ 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 economy and consumer welfare, anticompetitive conduct in health care markets has long been a key target of FTC law enforcement,¹¹ research,¹² and advocacy.¹³ Recently, FTC staff have analyzed the likely competitive effects of proposed APRN regulations in other states.¹⁴

II. BACKGROUND: APRN PRACTICE IN LOUISIANA AND HB951

APRNs are licensed by the Louisiana Board of Nursing and subject to the Board's regulations. Louisiana law defines advanced practice registered nursing as:

nursing by a certified registered nurse anesthetist, certified nurse midwife, clinical nurse specialist, or nurse practitioner which is based on knowledge and skills acquired in a basic nursing education program, licensure as a registered nurse, and a minimum of a master's degree with a concentration in the respective advanced practice nursing specialty which includes both didactic and clinical components, advanced knowledge in nursing theory, physical and psychosocial assessment, nursing interventions, and management of health care.¹⁵

As noted above, current law requires that an APRN must practice under a formal written collaborative practice agreement¹⁶ if he or she is to practice to the full extent of APRN scope of practice, as permitted under Louisiana law, including “acts of medical diagnosis and prescription.”¹⁷ Although collaborative agreements could, in theory, encompass varying arrangements, the IOM Report observes that Louisiana 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.¹⁸

III. LIKELY COMPETITIVE BENEFITS OF HB951

FTC staff recognize that certain professional licensure requirements are necessary to protect patients. Consistent with patient safety, we urge legislators to consider the potential benefits of competition, including improved access to care, lower costs, and increased options, that the passage of HB951 would likely enhance.

a. HB951 Would Likely Improve Access to Primary Care Services

The United States faces substantial and growing shortages of physicians.¹⁹ 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.²⁰ With respect to Louisiana specifically, the Louisiana Department of Health and Hospitals has observed that “[s]hortages affecting the accessibility and availability of primary-care physicians . . . pose a significant problem in the delivery of healthcare in Louisiana.”²¹ Louisiana also faces a shortage of APRNs – as it does with other primary care professionals.²²

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. In contrast, eliminating unnecessary restrictions may be especially beneficial where there are shortages of primary care providers, as is the case in medically underserved areas. In such areas, APRNs likely have limited choices of physicians with whom to seek collaborative agreements. You note, too, that practicing APRNs may find it difficult to secure a replacement agreement, and continue their treatment of patients, when a collaborating physician retires, moves, or dies.²³ Moreover, reduced competitive pressures on physicians practicing in underserved areas may enhance their ability to impose relatively high fees for maintaining such agreements.²⁴ If enacted, the Bill would eliminate the costs of these agreements – at least for APRNs who practice in medically underserved areas or treat medically underserved populations. That may indeed help APRNs establish or maintain cost-effective services where they are needed, thereby increasing access to primary and preventative care for the underserved.

Recent reports indicate that more than half of Louisiana's population lives in a federally-designated Health Professional Shortage Area ("HPSA").²⁵ All 64 Louisiana Parishes contain HPSAs,²⁶ and 53 entire Parishes comprise primary care shortage areas.²⁷ An estimated 765,000 Louisianans – more than 17 percent of the State's population – lack health insurance.²⁸ Federal health care reform may expand the number of people with insurance in Louisiana, which may further increase the demand for primary care services, and potentially exacerbate the imbalance between demand for and supply of primary care physicians. 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, especially in rural or underserved areas of Louisiana. 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 HPSAs. APRNs are more likely than primary care physicians to practice in underserved areas and to care for large numbers of minority patients, Medicaid beneficiaries, and uninsured patients.²⁹ In Louisiana there are approximately 3,500 licensed APRNs, and they practice in most of the state's designated HPSAs.³⁰ 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.³¹ Some reports suggest more APRNs practice in states that allow independent practice (i.e., practice without immediate supervision or collaborative agreement requirements).³² Thus, if Louisiana eliminates the requirement for a collaborative agreement for full practice authority for at least some APRNs, Louisiana may benefit from a growth in the number of APRNs.

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

b. HB951 Would Likely Increase Consumer Options and Lower Costs

HB951 is likely to increase consumer options and reduce the cost of basic health care services. APRN care is generally less expensive to patients and other payers and is often provided in a variety of health care delivery settings, so the Bill could, if enacted, spur innovation in health care delivery and widen the range of choices available to consumers.³³ For example, APRNs have played an important role in the expansion of limited service clinics ("LSCs") in many states. LSCs typically are staffed by APRNs³⁴ and offer consumers a convenient way to obtain basic medical care at competitive prices.³⁵ APRN-staffed clinics generally offer weekend and evening hours, which provide greater flexibility for patients, and may provide competitive incentives for other types of clinics to offer extended hours as well.³⁶ HB951, by eliminating restrictions on APRNs' ability to practice to their full scope of practice, may increase both the number and types of clinics available to Louisiana consumers.³⁷

Furthermore, if enacted, HB951 would likely decrease APRNs' costs of doing business, which could tend to lower the prices of APRN services, reducing costs for consumers as well as government and private third-party payers. You have advised that APRNs may face several difficulties under the existing requirement. First, securing a collaborative practice agreement may be a costly process for some APRNs – perhaps especially in underserved areas, where APRNs may find it difficult to find a physician who is able and willing to agree to collaborative practice; and perhaps more difficult still when a prior agreement is terminated because a collaborating physician retires, moves, or dies. Second, developing a sustainable APRN business may have to account for costly risks if physicians can revoke collaborative practice agreements at any time, for any reason. Finally, you have suggested that APRNs often must pay ten to forty-five percent of their collected fees to physicians for entering into collaborative practice agreements.³⁸

c. Legislative Consideration of Health and Safety Issues

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 training.³⁹ The IOM noted that 16 states and the District of Columbia allow APRNs to practice and prescribe independently, and that there were no differences in safety and quality between states with restrictive scope of practice laws and regulations and those that allow APRNs to practice independently.⁴⁰ We further note that HB951 does not otherwise change either the scope of APRN practice or established regulatory oversight of APRNs in Louisiana, 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

HB951 would remove the requirement that certain APRNs who practice in medically underserved areas or treat medically underserved populations have formal written collaborative practice agreements with physicians in order to fully employ their education and experience in serving Louisiana health care consumers. 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 requirement is necessary to assure patient safety in light of your own regulatory experience and the expert findings of the IOM. Maintaining an unnecessary and burdensome requirement is likely to deprive consumers of the benefits that increased competition can provide. Therefore, the Louisiana legislature should carefully consider the safety record of APRNs in Louisiana. Absent countervailing safety concerns regarding APRN practice, HB951 appears to be a procompetitive improvement in the law that would benefit Louisiana health care consumers.

Respectfully submitted,

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¹ 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.

² 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) [hereinafter Letter from Reps. Willmott & Williams].

³ *Id.*

⁴ *See generally* INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH (2011) [hereinafter IOM NURSING REPORT] (especially Summary, 1-15).

⁵ *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>.

⁶ Letter from Reps. Willmott & Williams (noting that APRNs often must pay 10-45% of their collected fees to physicians for entering into collaborative practice agreements).

⁷ *See, e.g.*, Louisiana Dep't Health and Hospitals, Bureau of Primary Care & Rural Health, Health Professional Shortage Area (HPSA) Maps, *available at* <http://new.dhh.louisiana.gov/index.cfm/newsroom/detail/2260> (last checked 03/30/12) (indicating primary care shortages in most of state); LOUISIANA DEP'T HEALTH AND HOSPITALS, OFFICE OF PUBLIC HEALTH, 2009 LOUISIANA HEALTH REPORT CARD, 224-6 (2010), *available at*

http://new.dhh.louisiana.gov/assets/oph/Center-RS/healthstats/DHHHlthCreRprtCrd_2009.pdf (describing large majority of state as “health professional shortage area” under LA criteria and MUA or MUP under federal criteria); 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 03/30/12) (indicating shortage areas throughout Louisiana’s 64 Parishes by HRSA criteria).

⁸ See, e.g., Louisiana State Board of Nursing, Louisiana Ctr. For Nursing, Nursing Workforce Demand Report March 2012, 1, 3 (2012).

⁹ Federal Trade Commission Act, 15 U.S.C. § 45.

¹⁰ 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.”).

¹¹ See FTC, An Overview of FTC Antitrust Actions in Health Care Services and Products (Dec. 2011), 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>.

¹² 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].

¹³ 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, Louisiana Legislature, (May 1, 2009) (regarding proposed restrictions on mobile dentistry), available at <http://www.ftc.gov/os/2009/05/V090009louisianadentistry.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 12.

¹⁴ FTC Staff Letter to the Honorable Paul Hornback, Senator, Commonwealth of Kentucky State Senate Concerning Kentucky Senate Bill 187 and the Regulation of Advanced Practice Registered Nurses (2012); 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>.

¹⁵ La. Rev. Stat. Ann. § 37:913(3)(a) (2012); see also La. Admin. Code LAC 46:XLVII.4505 (2012) (Louisiana State Board of Nursing regulations regarding APRNs).

¹⁶ A collaborative practice agreement is “a formal written statement addressing the parameters of the collaborative practice which are mutually agreed upon by the advanced practice registered nurse and one or more licensed physicians or dentists.” La. Rev. Stat. Ann. § 37:913(9) (2012).

¹⁷ La. Rev. Stat. Ann. § 37:913(8) (2012).

¹⁸ IOM FUTURE OF NURSING REPORT, *supra* note 4, at 158, Table 3-A1.

¹⁹ 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 (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/physwffissues.pdf>. [Hereinafter HRSA PHYSICIAN WORKFORCE REPORT].

²⁰ See Kaiser Commission, *Improving Access*, *supra* note 19, at 1.

²¹ LOUISIANA DEP’T HEALTH AND HOSPITALS, 2009 LOUISIANA HEALTH REPORT CARD, *supra* note 7, at 203.

²² LOUISIANA DEP’T HEALTH AND HOSPITALS, 2009 LOUISIANA HEALTH REPORT CARD, *supra* note 7, at 203.

²³ Letter from Reps. Willmott & Williams, *supra* note 2.

²⁴ See *supra* note 6 (noting high fees for collaborative practice agreements).

²⁵ See, e.g., 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 (indicating 57.8% of Louisiana population living in HPSA) (last checked (Apr. 9, 2012); National Conference of State Legislatures, Primary Care: State Profiles, available at <http://www.ncsl.org/issues-research/health/primary-care-state-profiles.aspx> (map indicating Louisiana as one of three states with 49-62% of population in HPSA) (last checked (Apr. 9, 2012). 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 (Apr. 9, 2012).

²⁶ U.S. Dep’t of Health and Human Servs., Health Resources and Services Administration, Find Shortage Areas by State and County, available at <http://hpsafind.hrsa.gov/HPSASearch.aspx> (last visited Mar. 30, 2012).

²⁷ LOUISIANA DEP’T HEALTH AND HOSPITALS, 2009 LOUISIANA HEALTH REPORT CARD, *supra* note 7, at 203 (citing August 2009 HRSA data).

²⁸ U.S. Census Bureau, Health Insurance Coverage Status 2008-2010, American Community Survey 3-Year Estimates, available at http://factfinder2.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_10_3YR_S2701&prodType=table (last checked Mar. 30, 2012).

²⁹ Kaiser Commission, *Improving Access*, *supra* note 19, at 3.

³⁰ Louisiana State Board of Nursing, 2010 Annual Report, 23 (2011).

³¹ See Kaiser Commission, *Improving Access*, *supra* note 19, at 3; AAMC, *Physician Shortages*, *supra* note 21.

³² 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 82nd Texas Legislature) (stating 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”).

³³ 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”).

³⁴ 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 LSCs); 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>.

³⁵ See Massachusetts Dept. Pub. Health, Commonwealth to Propose Regulations for Limited Service Clinics: Rules May Promote Convenience, Greater Access to Care (Jul. 17, 2007), available at http://www.mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=dphpressrelease&prFile=070717_clinics.xml. The types of care offered at LSCs are similar to those offered in urgent care centers and other limited care, outpatient settings. See, e.g., Ateev Mehrotra et al., *Retail Clinics, Primary Care Physicians, and Emergency Departments: A Comparison of Patients Visits*, 27 HEALTH AFFAIRS 1272, 1279 (2008).

³⁶ 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 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.”).

³⁷ See, e.g., TEXAS BUDGET BOARD STAFF REPORT, *supra* note 32, at 300 (noting restrictions on APRNs’ scope of practice may limit both the number and types of LSCs 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”).

³⁸ See *supra* note 6.

³⁹ IOM NURSING REPORT, *supra* note 4 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).

⁴⁰ *Id.* at 98-99 (noting “[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”). 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”); Cf. 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) (for retail clinic settings largely staffed by APRNs, 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”).