PREPARED STATEMENT OF

THE FEDERAL TRADE COMMISSION STAFF

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

September 10-12, 2012

I. INTRODUCTION

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] appreciate the opportunity to respond to Senator Daniel Foster's invitation for testimony on West Virginia's laws governing Advanced Practice Registered Nurses' ("APRNs'")[2] scope of practice, as well as for recommendations the FTC staff deem "appropriate to protect the public while simultaneously allowing for an efficient and procompetitive market."[3] Senator Foster specifically noted that West Virginia law allows APRNs to diagnose and treat patients without physician involvement, but requires APRNs to have a signed collaboration agreement with a physician in order to prescribe medications.

Senator Foster's invitation highlights West Virginia Senate Concurrent Resolution No. 93, which recommends a study of "the scope of practice of advanced practice nurses and the need for its expansion to improve the quality of health care, increase patient access and to allow patients free choice of their health care providers."[4] Senator Foster states that the review of current law is in part responsive to the Institute of Medicine's ("IOM") request that state legislatures review and reform, if necessary, scope of practice regulations on APRNs.[5] He further indicated that this review is an opportunity for the West Virginia legislature to fulfill its duty to provide West Virginians "with a healthcare marketplace that is safe, open, and robust."[6]

As Concurrent Resolution No. 93 recognizes, recent reports by the IOM have identified a key role for advanced practice nurses in improving the delivery of health care.[7] 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 can help improve access to health care and "[r]estrictions on scope of practice. . . have undermined [nurses'] ability to provide and improve both general and advanced care."[8]

West Virginians are particularly vulnerable to access issues caused by physician shortages. West Virginia currently suffers from shortages of primary care providers, and these shortages are expected to worsen as more West Virginians gain health insurance and seek access to primary health care services.[9] Legislative action to eliminate the collaborative agreement requirement for prescriptive authority may improve access and consumer choice for primary care services, especially for rural and other underserved populations, and also may encourage beneficial price competition that could help contain health care costs.

Given the potential benefits of eliminating unwarranted impediments to APRN practice, we applaud the West Virginia legislature's efforts to review and study the statutory limits on APRNs, and we recommend that the legislature ensure that such limits are no stricter than patient protection requires. We encourage the legislature to carefully consider available safety evidence on APRN practice in West Virginia and elsewhere. Absent a finding that there are countervailing patient care and safety concerns regarding APRN practice, suggestions to remove

the collaborative agreement for prescriptive authority appear to be a procompetitive improvement in the law that likely would benefit West Virginia health care consumers.

II. 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.[10] Competition is at the core of America's economy,[11] 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,[12] research,[13] and advocacy.[14] Recently, FTC staff have analyzed the likely competitive effects of proposed APRN regulations in other states.[15]

III. BACKGROUND: APRN PRACTICE IN WEST VIRGINIA

APRNs are licensed by the West Virginia Board of Examiners for Registered Professional Nursing and subject to the Board's regulations.[16] West Virginia law states:

> The practice of "advanced practice registered nurse" is a registered nurse who has acquired advanced clinical knowledge and skills preparing him or her to provide direct and indirect care to patients, who has completed a board-approved graduate-level education program and who has passed a board-approved national certification examination. An advanced practice registered nurse shall meet all the requirements set forth by the board by rule for an advance practice registered nurse which shall include, at a minimum, a valid license to practice as a certified registered nurse anesthetist, a certified nurse midwife, a clinical nurse specialist or a certified nurse practitioner.[17]

APRNs were first recognized by the West Virginia Legislative Rules beginning in 1991.[18] In 1993, the requirements for prescriptive authority were set forth in the West Virginia Code and Legislative Rules, including the requirement that prescribing APRNs have a signed collaboration agreement with a West Virginia physician.[19] Although collaborative agreements could, in theory, encompass varying arrangements, the IOM Report observes that West Virginia 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.[20]

IV. LIKELY COMPETITIVE BENEFITS OF EXPANDING APRN PRESCRIPTIVE AUTHORITY

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 removal of restrictions on APRN practice would likely create.

a. Removing Restrictions Is Likely to Improve Access to Primary Care Services

The United States faces substantial and growing shortages of physicians.[21] 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 to fewer physician practices located in low-income communities, as well as low physician participation in state Medicaid programs.[22]

The West Virginia legislature recognized access problems in Resolution No. 93: "The health care model in place, despite its established history, has not been successful in providing care to all patients in West Virginia, including the uninsured."[23] In fact, 44 of 55 West Virginia counties contain federally-designated Health Professional Shortage Areas ("HPSAs").[24] Moreover, federal health care reform will greatly expand the number of people with insurance in West Virginia, likely increasing the demand for primary care services and potentially exacerbating the imbalance between demand for and supply of primary care physicians. Beginning in 2014, as many as 178,300 West Virginians will be eligible for tax credits to purchase private health insurance policies and an additional 122,000 low-income West Virginians may become eligible for Medicaid.[25]

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.[26] 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.[27] 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.[28]

There are currently 1,454 APRNs licensed in West Virginia, of which approximately 1,000 are primary care nurse practitioners. APRNs live in 49 of West Virginia's 55 counties and practice in 54 of the state's 55 counties, which suggests that greater utilization of West Virginia's APRNs could improve access to care.[29] Moreover, some reports suggest more APRNs practice in states that allow independent practice (*i.e.*, practice without immediate supervision or collaborative agreement requirements).[30] As the West Virginia legislature noted, "[a]dvanced practice nursing scope of practice is increasingly expanding in other states, including the border state of Maryland, thus decreasing the likelihood of keeping the best advanced practice nurses in West Virginia."[31] Thus, if West Virginia were to eliminate the requirement for a collaborative agreement for prescriptive authority, it might prevent the loss of APRNs to less restrictive states and might benefit from growth in the number of APRNs choosing to practice there.

In sum, unnecessary restrictions on APRNs may result in decreased access to health care services, with potentially harmful consequences for West Virginia patients.

b. Removing Restrictions Would Likely Lower Costs and Increase Consumer Options

Removing the requirement that APRNs have a collaborative agreement with a physician in order to prescribe medications is likely to reduce the cost of basic health care services and could spur innovation in health care delivery and widen 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.[32] Similar to the situation in other states, there is anecdotal evidence suggesting some West Virginia 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 for prescriptive authority.[33] Unless these arrangements involve true and beneficial supervision,[34] 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).

It is also our understanding that some APRNs who are attempting to establish an independent practice find it difficult to identify a physician willing to enter into a collaborative prescribing agreement at all.[35] Other APRNs find it difficult to develop a sustainable business because collaborating physicians can revoke collaborative agreements at any time for any reason, which compromises APRNs' ability to treat their patients.[36] For example, if an APRN's collaboration agreement for prescriptive authority with a physician ends, the APRN could continue to see patients, but could not continue to prescribe needed medications, compromising their ability to meet the needs of their patients.

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.[37] Retail clinics generally offer weekend and evening hours, which provide greater flexibility for patients,[38] and appear to provide competitive incentives for other types of physician practices to offer extended hours as well.[39] If the West Virginia legislature decides to relax restrictions on APRNs' ability to prescribe medications, such action might increase both the number and types of care settings available to West Virginia consumers.[40]

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 West Virginia collaboration requirement provides any additional patient protection.[41] 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.[42] 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.[43] 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."[44]

V. CONCLUSION

Removing the requirement that APRNs who want to prescribe medications have a collaborative agreement with a physician has the potential to benefit consumers by expanding choices for patients, containing costs, and improving access. Maintaining an unnecessary and burdensome requirement is likely to deprive consumers of the benefits that increased competition can provide. Accordingly, we encourage the West Virginia legislature to carefully review the safety record of APRNs in West Virginia and to consider whether the current requirement is necessary to assure patient safety in light of the almost twenty years of prescribing experience of West Virginia APRNs, as well as the findings of the Institute of Medicine. Absent countervailing safety concerns regarding APRN prescribing practices, removing the collaborative agreement for prescriptive authority appears to be a procompetitive improvement in the law that would benefit West Virginia health care consumers.

Respectfully submitted,

Andrew I. Gavil, Director
Office of Policy Planning

Richard A. Feinstein, Director
Bureau of Competition

Howard Shelanski, Director
Bureau of Economics

[1] This staff testimony expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The testimony 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 this testimony.

[2] The Institute of Medicine (IOM) and others use the term APRN to include nurse practitioners, certified nurse midwives, certified registered nurse anesthetists, and clinical nurse specialists. West Virginia law was recently amended to replace the term "advanced nurse practitioner" with "advanced practice registered nurse." See Senate Bill No. 572, amending W.VA. CODE § 30-7-1. To simplify the foregoing discussion, our testimony uses the term APRN, but our comments focus on the statutory restrictions and evidence related specifically to APRNs who provide primary care services, previously referred to in West Virginia laws and regulations as "advanced nurse practitioners" or ANPs. Certified Nurse Midwives ("CNMs") in West Virginia currently must have a collaborative agreement in place to practice, treat, and prescribe medications. To the extent that CNMs provide primary care for women, including gynecological exams and prescriptions, it is possible the same reasoning for removing restrictions on nurse practitioners could apply to this aspect of CNMs' practice. Certified Registered Nurse Anesthetists ("CRNAs") in West Virginia can only practice under the supervision of a physician; our testimony does not address CRNA supervision requirements.

[3] Letter from The Hon. Daniel Foster, The Senate of West Virginia, to the Office of Policy Planning, Bureau of Economics, and Bureau of Competition, Federal Trade Commission (May 3, 2012) [hereinafter Letter from Sen. Foster].

[4] Letter from Sen. Foster; West Virginia Senate Concurrent Resolution No. 93, *available at* http://www.legis.state.wv.us/Bill_Text_HTML/2012_SESSIONS/RS/Bills/scr93%20intr.htm.

[5] See INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH, *available at* http://www.iom.edu/Reports/2010/The-Future-of-Nursing-Leading-Change-Advancing-Health.aspx [hereinafter IOM NURSING REPORT] at 4-5, 9-15, 29-30 (2011) (discussing need for federal and state actions "to update and standardize scope-of-practice regulations to take advantage of the full capacity and education of APRNs"); *id.* at 10 (recommending specifically state legislatures "[r]eform scope-of-practice regulations to conform to the National Council of State Boards of Nursing Model Nursing Practice Act and Model Nursing Administrative Rules").

[6] Letter from Sen. Foster.

[7] *See generally* IOM NURSING REPORT, *supra* note 5.

[8] *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.

[9] *See* discussion *infra* at Section IV.a. and notes 23-25 and accompanying text (discussing primary care provider shortages and the number of West Virginians who could gain health care coverage over the next few years as a result of the Affordable Care Act).

[10] Federal Trade Commission Act, 15 U.S.C. § 45.

[11] 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.").

[12] *See* FTC, An Overview of FTC Antitrust Actions in Health Care Services and Products (June 2012), *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.

[13] *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].

[14] 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.,* FTC Staff Letter to The Hon. Stephen LaRoque, North Carolina House of Representatives (May 2012) (regarding the regulation of dental service organizations and the business organization of dental practices), *available at* http://www.ftc.gov/os/2012/05/1205ncdental.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 13.

[15] 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; 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;

[16] Although West Virginia law was recently revised to use the term "Advanced Practice Registered Nurse," more broadly, the law continues to specify separate requirements, including supervision by a physician, for Certified Nurse-Midwives (W.VA. CODE §§ 30-15-1 – 8) and Certified Registered Nurse Anesthetists (W.VA. CODE § 30-7-15).

[17] W.VA. CODE § 30-7-1, as amended by Senate Bill 572 (2012). *See also* W.VA. CODE R. § 19-7-2 (Title 19, Legislative Rule, Board of Registered Professional Nurses, Series 7: Announcement of Advanced Practice Registered Nurse) and proposed revisions, recently filed with the West Virginia Secretary of State and the Legislative Rulemaking Review Committee at http://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=24012&Format=PDF. *See* explanation of Legislative Rules, *infra,* note 18.

[18] W.VA. CODE R. §§ 19-7-1 to 4. According to the West Virginia Secretary of State's website, "[l]egislative rules are proposed by an agency subject to the Administrative Procedure Act (APA), but must be approved by the Legislature before they go into effect, unless they are filed as Emergency rules. A legislative rule is the only form of rule under the APA which: carries the force of law, or supplies a basis of civil or criminal liability, or grants or denies a specific benefit." STATE OF WEST VIRGINIA, WEST VIRGINIA SECRETARY OF STATE, ADMINISTRATIVE LAW, RULE MAKING, TYPES OF RULES, http://www.sos.wv.gov/administrative-law/rulemaking/Pages/types.aspx (last visited Sept. 6, 2012). *See also* W.VA. CODE §29A-3-11 (explaining that a proposed rule must be submitted by the state agency to the legislative rulemaking review committee, which has the following options after reviewing the legislative rule: "the committee shall recommend that the Legislature: (1) Authorize the promulgation of the legislative rule; or (2) Authorize the promulgation of part of the legislative rule; or (3) Authorize the promulgation of the legislative rule with certain amendments; or (4) Recommend that the proposed rule be withdrawn.").

[19] *See* W.VA. CODE §§ 30-7-15a –c, as amended by Senate Bill 535 (2012) (the law as amended maintains the collaborative agreement and other related requirements, but allows APRNs to prescribe medications for chronic conditions other than chronic pain for up to one year (prior regulations limited most prescriptions to a six-month supply or less) and to prescribe anticoagulants (prior law prohibited such prescriptions)); W.VA. CODE R. §§ 19-8-1 to 6 (Title 19, Legislative Rule, Board of Registered Professional Nurses, Series 8: Limited Prescriptive Authority for Nurses in Advanced Practice) and proposed revisions, recently filed with the West Virginia Secretary of State and the Legislative Rulemaking Review Committee at http://apps.sos.wv.gov/adlaw/csr/readfile.aspx?DocId=24006&Format=PDF. *See also* West Virginia Board of Examiners for Registered Professional Nurses, instructions for collaborative agreements for prescriptive authority, *available at* http://www.wvrnboard.com/images/initial%20application%20for%20prescriptive%20authority.pdf (the APRN must certify that the collaborative agreement includes: 1) agreed upon written guidelines or protocols; 2) statements describing the individual and shared responsibilities of the APRN and the physician; 3) provision for the periodic and joint evaluation of the prescriptive practice; and 4) provision for the periodic and joint review and updating of the written guidelines or protocols).

[20] IOM FUTURE OF NURSING REPORT, *supra* note 5, at 158, Table 3-A1.

[21] *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) (noting by 2020 the U.S. will face an estimated shortage of 91,000 physicians, with a projected shortfall of approximately 45,000 primary care physicians and 46,000 specialists), *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. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RESOURCES & SERVS. ADMIN. BUREAU OF HEALTH PROFESSIONS, THE PHYSICIAN WORKFORCE: PROJECTIONS AND RESEARCH INTO CURRENT ISSUES AFFECTING SUPPLY AND DEMAND [hereinafter HRSA PHYSICIAN WORKFORCE REPORT] 70-72, exhibits 51-52 (2008), *available at* http://bhpr.hrsa.gov/healthworkforce/reports/physwfissues.pdf; Annie Lowrey & Robert Pear, *Doctor Shortage Likely to Worsen With Health Law*, NY TIMES (July 28, 2012), *available at* http://www.nytimes.com/2012/07/29/health/policy/too-few-doctors-in-many-us-communities.html.

[22] *See* Kaiser Commission, *Improving Access*, *supra* note 21, at 1; Leighton Ku et al., *The States' Next Challenge – Securing Primary Care for Expanded Medicaid Populations*, 364 N. ENGL. J. MED. 493, 494 (2011).

[23] West Virginia Senate Concurrent Resolution No. 93, *available at* http://www.legis.state.wv.us/Bill_Text_HTML/2012_SESSIONS/RS/Bills/scr93%20intr.htm.

[24] U.S. Dep't of Health & Human Servs., Health Resources & Servs. Admin., Find Shortage Areas by State and County, *available at* http://hpsafind.hrsa.gov/HPSASearch.aspx (last visited July 27, 2012).

[25] West Virginians for Affordable Care, *The Affordable Care Act: Moving Forward in West Virginia*, at 4 (Apr. 2011), *available at* http://www.wvahc.org/downloads/ACA-Moving_Forward_in_WV041611.pdf. *See also* Jennifer Sullivan and Kathleen Stoll, *Lower Taxes, Lower Premiums: The New Health Insurance Tax Credit in West Virginia*, Families USA (Sept. 2010), *available at* http://www familiesusa.org/assets/pdfs/health-reform/premium-tax-credits/West-Virginia.pdf; John Holahan and Irene Headen, *Medicaid Coverage and Spending in Health Reform: National and State-by-State Results for Adults at or Below 133% FPL*, Kaiser Commission on Medicaid and the Uninsured (May 2010), *available at* http://www kff.org/healthreform/upload/Medicaid-Coverage-and-Spending-in-Health-Reform-National-and-State-By-State-Results-for-Adults-at-or-Below-133-FPL.pdf. It is unclear what impact, if any, the U.S. Supreme Court's recent decision on the Medicaid provisions of the ACA will have on West Virginia's decisions with respect to expanding Medicaid. *See generally National Federation of Independent Business v. Sebelius*, No. 11–393 (U.S. Sup. Ct. June 28, 2012).

[26] Kaiser Commission, *Improving Access*, *supra* note 21, at 3. The statistics for West Virginia suggest that APRNs could be especially helpful for addressing access issues. For example, approximately 43% of the population resides in non-metropolitan areas, compared to an average of 16% of the U.S. population (Kaiser Family Foundation, State Health Facts: West Virginia, Population Distribution by Metropolitan Status, *available at* http://www.statehealthfacts.org/profileind.jsp?ind=18&cat=1&rgn=50). "21.6% of West Virginia's adults aged 18 - 64 lacked any kind of health care coverage, compared with a national average of 18.2%;" and approximately "17.2% of West Virginia's population lives below the poverty level, compared with 13.2% of the national population." WEST VIRGINIA DEPARTMENT OF HEALTH & HUMAN RESOURCES, ADVOCATING FOR CHRONIC DISEASE MANAGEMENT AND PREVENTION at 6, 4 (May 2011), *available at* http://www.wvcancer.com/Portals/9/Chronic%20Disease%20Strategic%20Plan%202011.pdf.

[27] *See* Kaiser Commission, *Improving Access*, *supra* note 21, at 3; AAMC, *Physician Shortages*, *supra* note 21.

[28] *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 (not including West Virginia),

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).

[29] West Virginia Board of Examiners for Registered Professional Nurses, ANNUAL REPORT OF THE BIENNIUM, July 1, 2009 – June 30, 2011, at pp. 84-85, 90-91, 100-101, *available at* http://www.legis.state.wv.us/legisdocs/reports/agency/R02_FY_2011_1330.pdf.

[30] *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").

[31] West Virginia Senate Concurrent Resolution No. 93, *available at* http://www.legis.state.wv.us/Bill_Text_HTML/2012_SESSIONS/RS/Bills/scr93%20intr htm.

[32] *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").

[33] FTC staff discussions with representatives of organizations that represent APRNs in West Virginia indicated one APRN pays a collaborating physician approximately $20,000 per year based on a percentage of the APRN's monthly revenue and another pays the physician an hourly rate for the collaboration. Although the West Virginia Center for Nursing website at http://www.wvcenterfornursing.org/pdf/WVStateDataSnapshotARNs.pdf provides data suggesting a large percentage of APRNs in West Virginia have prescriptive authority, it is our understanding from our discussions that most of these APRNs work as employees of physicians or other health care institutions. 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).

[34] *See* discussion in Section III *supra*.

[35] *See* discussion in note 36 *infra*. *See also* Letter from Sen. Foster (noting the "WV Board of Medicine has promulgated collaborative agreement guidelines with additional recommended restrictions"); West Virginia Board of Medicine, guidelines for collaborative agreements, *available at* http://www.wvbom.wv.gov/collnurse.pdf.

[36] *See, e.g.,* WEST VIRGINIA NURSE, Vol.15, No. 3 at p. 9 (Aug., Sept., Oct. 2012), *West Virginians Denied Access to Chronic Care Due to Bogus Warning to Physicians*, *available at* http://www.aldpub.com/West_Virginia/West_Virginia.pdf. The article noted that one nurse practitioner (Toni DiChiacchio) had to halt plans to open a chronic disease management clinic because the "collaborating physician, who was interested in the services the clinic could provide, was "spooked" by not only his malpractice insurance company but the WV Board of Medicine," which incorrectly told the physician that he would have a greater risk of malpractice by collaborating with a nurse practitioner. The President of the WV Nurses Association stated this was not an isolated case and that: "These warnings and increasingly restrictive guidelines from the BOM to WV physicians make it harder for APRNs to get an agreement signed. Without an agreement, needed services like Toni's clinic must close their doors. We are very concerned for our patients. There is already a shortage of

providers and WV is losing APRNs to neighboring states that realize collaborative agreements are unnecessary. Research proves advanced practice registered nurses provide high quality, safe care." *See also* W.VA. CODE §§ 55-7B-1 to 12 (dealing with medical malpractice and professional liability and stating in § 55-7B-9 that "a health care provider may not be held vicariously liable for the acts of a nonemployee pursuant to a theory of ostensible agency unless the alleged agent does not maintain professional liability insurance covering the medical injury which is the subject of the action in the aggregate amount of at least one million dollars").

[37] *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 [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").

[38] *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.").

[39] *See* Rand, *Policy Implications of the Use of Retail Clinics* at 13, *supra* note 37 (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").

[40] *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").

[41] *See* discussion in Section III *supra* at note 20 and accompanying text.

[42] 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).

[43] IOM NURSING REPORT, *supra* note 5 at 98.

[44] *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").