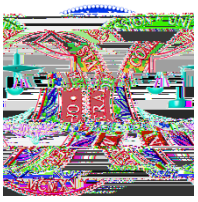

UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

February 10, 2016

The Hon. Kent Leonhardt
Senate of West Virginia
State Capitol, Room 200W
Charleston, WV 25305

Dear Senator Leonhardt:

The staffs of the Federal Trade Commission Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] appreciate the opportunity to respond to your invitation for comments on the likely competitive impacts of Senate Bill 516, as amended by the Senate Health Committee during the 2015 session ("S. 516" or "the Bill").[2] In particular, you asked that we comment on the likely competitive effect of the amendment to the Bill that would place the regulation of certain advanced practice registered nurses ("APRNs") under the authority of the West Virginia Board of Medicine or Board of Osteopathy.[3] For reasons explained below, we urge the West Virginia legislature to avoid restrictions on APRN practice that are not narrowly tailored to address well-founded patient safety concerns.

The competitive implications of various APRN regulations, including mandatory collaborative practice agreements, are analyzed in the attached 2014 FTC staff policy paper, Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses.[4] As explained in the policy paper, FTC staff recognize the critical importance of patient health and safety, and we defer to state legislators to determine the balance of policy priorities and to define the appropriate scope of practice for APRNs and other health care providers. But well-intentioned laws and regulations may entail unnecessary, unintended, or overbroad restrictions on competition. Undue regulatory restrictions on APRN practice can impose significant costs on health care consumers – patients – as well as both public and private third-party payors. The FTC staff policy paper observes, in particular, that state-mandated "collaborative practice" agreements raise considerable competitive concerns, potentially impeding access to care and frustrating the development of innovative and effective models of team-based health care.[5] We recommend that the West Virginia legislature consider these effects when evaluating the regulatory reforms in S. 516 or similar proposals.

Expert bodies, including the Institute of Medicine ("IOM"),[6] have determined that APRNs are "safe and effective as independent providers of [primary and routine care services]."[7] We recommend that you examine carefully purported safety justifications for West Virginia's current APRN collaborative

agreement requirements in light of the pertinent evidence,

3) Has a recommendation from his or her collaborative physician which recommends that the [APRN] be permitted to prescribe without a collaborative arrangement[15]

The Bill stipulates, however, that two significant categories of APRNs – CNMs and CRNAs – "shall not be permitted to prescribe without a collaborative agreement."[16] Finally, the remainder of West Virginia APRNs who did not (or could not) secure a prescribing license would still require a "standardized written agreement"

report noted the high quality of primary care services provided by APRNs, who “may be able to

strict. Several provisions of S. 516 are concerning in that regard. First, the Bill would only permit APRNs "working solely in an area that has been designated . . . as a Health Professional Shortage Area" to secure a prescribing license.[67] Access to basic health care services in HPSAs is important and, as we have discussed, justifies strict scrutiny of APRN practice restrictions. Yet there is no clear reason why only APRNs working in HPSAs should be eligible for prescribing licenses. Moreover, APRNs – and institutional providers employing APRNs –

and application of occupational restrictions that discourage new entrants, deter competition among licensees and from providers in related fields, and suppress innovative products or services that could challenge the status quo.[72]

In North Carolina State Board of Dental Examiners v. FTC, similar concerns about professional bias and its effects on competition helped explain limits to a state regulatory board's ability to insulate itself against allegations of anticompetitive conduct.[73] There, the dentist-dominated board had sought to exclude non-dentists from providing basic teeth-whitening services using non-prescription materials. In that case, the U.S. Supreme Court observed that, "established ethical standards may blend with private anticompetitive motives in a way difficult even for market participants to discern. Dual allegiances are not always apparent to an actor."[74]

IV. CONCLUSION

Absent countervailing safety concerns regarding APRN practice, removing extant supervision requirements to permit independent APRN prescribing has the potential to benefit consumers by improving access to care, containing costs, and expanding innovation in health care delivery. S. 516 could benefit patients, as it would permit a route to independent prescribing, at least for some APRNs, at least under certain conditions. The Bill raises significant competitive concerns nonetheless, first because of the many conditions and exclusions it would impose on independent APRN prescribing, and second because of the many conflicts of interest that appear to be inherent in the Bill's requirements of physician permission for and oversight of APRN prescribing. Accordingly, we encourage the legislature to consider whether these requirements are necessary to assure patient safety in light of West Virginia's own regulatory experience, the findings of the IOM and other expert bodies, and the experience of other states. Removing unnecessary and burdensome requirements may benefit West Virginia consumers by increasing competition among health care providers.

Respectfully submitted,

Marina Lao, Director
Office of Policy Planning

Ginger Jin, Director
Bureau of Economics

Deborah Feinstein, Director
Bureau of Competition

[1]

[12] FTC and staff advocacy may consist of 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 Timothy G. Burns, Representative, La. House of Representatives (May 1, 2009), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-

[20] According to the National Council of State Boards of Nursing, 22 states and the District of Columbia, permit independent prescribing for certified nurse practitioners, Nat'l Council State Bds. Nursing, CNP Independent Prescribing Map, https://www.ncsbn.org/5408.htm (checked 12/10/15); 20 states and the District of Columbia permit independent prescribing for nurse anesthetists, Nat'l Council State Bds. Nursing, CRNA Independent Prescribing Map, https://www.ncsbn.org/5408.htm (checked 12/10/15); and 21 states and the District of Columbia

lower costs and prices that tend to be associated with APRN-delivered services: "between 2010 and 2020, Massachusetts could save $4.2 to $8.4 billion through greater reliance on NPs and PAs in the delivery of primary care." CHRISTINE E. EIBNER ET AL., RAND HEALTH REPORT SUBMITTED TO THE COMMONWEALTH OF MASSACHUSETTS, CONTROLLING HEALTH CARE SPENDING IN MASSACHUSETTS: AN ANALYSIS OF OPTIONS, 103-104 (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR736.pdf (describing conditions for upper and lower bound estimates and projections).

[29] FTC STAFF POLICY PERSPECTIVES, supra note 4, at 27-28.

[30] "Expanded APRN practice is widely regarded as a key strategy to alleviate provider shortages, especially in primary care, in medically underserved areas, and for medically underserved populations." FTC STAFF POLICY PERSPECTIVES, supra note 4, at 20 (citing, e.g. IOM FUTURE OF NURSING REPORT, supra note 7, at 98-103, 157-61 annex 3-1 (2011); CHRISTINE E. EIBNER ET AL., RAND HEALTH REPORT SUBMITTED TO THE COMMONWEALTH OF MASSACHUSETTS, CONTROLLING HEALTH CARE SPENDING IN MASSACHUSETTS: AN ANALYSIS OF OPTIONS 99 (2009), http://www.rand.org/content/dam/rand/pubs/technical_reports/2009/RAND_TR736.pdf; NAT'L GOVERNORS ASS'N, NGA PAPER, supra note 26.

[31] The National Governors Association recognized the impact of this supply expansion in its NGA PRIMARY CARE PAPER, supra note 30.

[32] FTC STAFF POLICY PERSPECTIVES, supra note 4, at 34.

[33] Regarding diverse practice settings and collaboration, see IOM FUTURE OF NURSING REPORT, supra note 7, at 23, 58-59, 65-67, 72-76; see generally Pamela Mitchell et al., Core Principles & Values of Effective Team-Based Health Care (Discussion Paper, Institute of Medicine 2012), http://nam.edu/wp-content/uploads/2015/06/VSRTeam-BasedCarePrinciplesValues.pdf (IOM-sponsored inquiry into collaborative or team-based care).

[34] A report by the Robert Wood Johnson Foundation describes several private and public models of innovative ways to use APRNs in team-based care. ROBERT WOOD JOHNSON FOUND., HOW NURSES ARE SOLVING SOME OF PRIMARY CARE'S MOST PRESSING CHALLENGES (2012), http://www.rwjf.org/content/dam/files/rwjf-web-

[62] For example, in 2001, the Centers for Medicaid and Medicare Services concluded that anesthesia services generally were safe and, in particular, that there was "no need for Federal intervention in State professional practice laws governing [CRNA] practice. . . . [and] no reason to require a Federal rule mandating that physicians supervise the practice of [state-licensed CRNAs]." Dep't Health and Human Servs. (HHS), Health Care Financing Administration (HCF A), Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services, 42 CFR §§416, 482-485, Final Rule, 66 Fed. Reg. 4674, 4675 (Jan. 18, 2001); HHS Health Care Financing Administration (HCF A), Medicare and Medicaid Programs; Hospital Conditions of Participation: Anesthesia Services, 42 CFR §§ 416, 482 &&