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

Office of Policy Planning
Bureau of Competition
Bureau of Economics

January 09, 2020

The Honorable Daniel R. Hawkins
Kansas House of Representatives
State Capitol
Topeka, KS 66612

Dear Representative Hawkins:

The Federal Trade Commission ("FTC" or "Commission") Office of Policy Planning appreciates the opportunity to respond to your request for comments on 2019 House Bill 2412 ("H.B. 2412" or "the Bill"), a proposal to expand the scope of practice of Advanced Practice Registered Nurses ("APRNs") in Kansas.[1] In particular, you asked for our input on the Bill's proposal to "permit APRNs full practice authority by eliminating a requirement that APRNs must have a collaborative practice agreement executed with a physician in order to prescribe medications."[2] You have also asked for our comment on a proposed amendment "to require all APRNs to be under the regulatory control of the physician-controlled Kansas Board of Healing Arts rather than the Kansas Board of Nursing where they are currently regulated."[3] For reasons explained below, we urge the Kansas legislature to enact H.B. 2412 and rescind the collaborative agreement requirement; in doing so, we urge you not to adopt the proposed amendment regarding regulation by the Board of Healing Arts.

FTC staff's interest in nursing regulation derives from our expertise in health care competition issues. The enclosed 2014 FTC staff policy paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses* ("Policy Paper"), analyzes the competitive implications of various Advanced Practice Registered Nurse ("APRN") regulations, including mandatory physician-supervision or "collaborative practice" agreements.[4] As

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[1] Letter from the Daniel R. Hawkins to Bilal Sayyed, Director, FTC Office of Policy Planning (Jul. 29, 2019).

[2] *Id.*

[3] *Id.*

[4] FED. TRADE COMM'N STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf [hereinafter FTC STAFF POLICY PAPER]. As noted in the FTC STAFF POLICY PAPER, "a state may impose certain 'collaborative practice' requirements on APRNs, requiring that an APRN enter into a written agreement with a physician to define the parameters of the APRN's permitted practice. This can be viewed as a *de facto* supervision requirement, to the extent that the APRN cannot practice without

explained in the Policy Paper, FTC staff recognize the critical importance of patient health and safety, and we defer to federal and state legislators to determine the best balance of policy priorities and to define the appropriate scope of practice for APRNs and other health care professionals. But even well-intentioned laws and regulations may include unnecessary or overbroad restrictions that limit competition. Undue regulatory restrictions on APRN practice can harm patients, institutional health care providers, and both public and private third-party payors. The Policy Paper observes that state-mandated supervision of APRN practice raises competitive concerns and may, in particular, raise the cost of care, impede access to care, and frustrate the development of innovative and effective models of team-based health care.[5]

As noted in the Policy Paper, the competitive risks associated with undue APRN restrictions may be heightened in rural and other medically underserved areas.[6] For that reason, the legislature may wish to focus not just on average or aggregate benefits that the Bill may promote for Kansas as a whole, but on health care cost and access problems facing, for example, the 66 Kansas counties that are Governor-Designated Medically Underserved Areas,[7] based on assessed shortages of primary care physicians.[8]

Expert bodies, including the Institute of Medicine ("IOM"),[9] have determined that APRNs are "safe and effective as independent providers of many health care services within the scope of their training, licensure, certification and current practice."[10] FTC staff have recommended, therefore, that policy makers carefully examine purported safety justifications for restrictions on APRN practice in light of the pertinent evidence, evaluate whether such justifications are well founded, and consider whether less restrictive alternatives would protect patients without imposing undue burdens on competition and undue limits on patients' access to basic health care services.

FTC staff urge the Kansas legislature to apply a similar analytical framework. Granting prescribing authority to Kansas APRNs would benefit Kansas health care consumers – patients, first and foremost, and both public and private third-party payors. APRNs should be able to evaluate patients and prescribe medications as needed, as long as they do so within the limits of

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securing the approval of an individual physician, whereas the terms of physician practice are in no way dependent on APRN input." *Id.* at 11.

[5] *Id.* at 38.

[6] *See, e.g., id.* at 21-25.

[7] Letter from Lee Norman, Secretary, Kansas Dep't Health & Environment, to Melissa Ryan, Health Resources & Servs. Admin. (Dec. 2, 2019), http://www.kdheks.gov/olrh/sd_resources/Governor_Certfied_Areas_Designations.pdf.

[8] Kansas Dep't Health & Environment, 2018 Health Professional Underserved Area Report: (2019), http://www.kdheks.gov/olrh/download/2018_Underserved_Areas_Report.pdf.

[9] The IOM—established in 1970 as the health arm of the National Academy of Sciences—provides expert advice to policy makers and the public.

[10] FTC STAFF POLICY PAPER, *supra* note 4, at 2 n.6 and accompanying text (*citing* INST. OF MED., NAT'L ACAD. OF SCIENCES, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 98–99 (2011) [hereinafter IOM FUTURE OF NURSING REPORT]).

their education and training. Twenty-two states and the District of Columbia already permit such APRN prescribing, to the benefit of their patients and payors;[11] and we recommend that you consider the likely benefits of the Bill in light of their experience.

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.[12] Competition is at the core of America's economy,[13] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, and greater innovation. "[C]ompetition among employers [also] helps actual and potential employees through higher wages, better benefits, or other terms of employment."[14] 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 focus of FTC law enforcement,[15] research,[16] and advocacy.[17] In

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[11] 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, State Practice Environment Map, https://www.aanp.org/advocacy/state/state-practice-environment (checked 12/08/19).

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

[13] Standard Oil Co. v. Fed. Trade Comm'n, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[14] FED. TRADE COMM'N & U.S. DEPT'T OF JUSTICE, ANTITRUST GUIDANCE FOR HUMAN RESOURCE PROFESSIONALS 2 (2016), https://www.ftc.gov/system/files/documents/public_statements/992623/ftc-doj_hr_guidance_final_10-20-16.pdf.

[15] *See* Fed. Trade Comm'n, Competition in the Health Care Marketplace, Cases, https://www.ftc.gov/tips-advice/competition-guidance/industry-guidance/health-care.

[16] *See* FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), https://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723healthcarerpt.pdf [hereinafter FTC & DOJ, IMPROVING HEALTH CARE]; Fed. Trade Comm'n, The Strength of Competition in the Sale of Rx Contact Lenses: An FTC Study (2005), (https://www.ftc.gov/sites/default/files/documents/reports/strength-competition-sale-rx-contact-lenses-ftc-study/050214contactlensrpt.pdf.

[17] 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.*, Joint Statement of the Fed. Trade Comm'n and the Antitrust Div. of the U.S. Dep't Justice Regarding Certificate-of-Need (CON) Laws and Alaska Senate Bill 62, Which Would Repeal Alaska's CON Program (2017), https://www.ftc.gov/system/files/documents/advocacy_documents/joint-statement-federal-trade-commission-antitrust-division-us-department-justice-regarding/v170006_ftc-doj_comment_on_alaska_senate_bill_re_state_con_law.pdf; FTC Staff Comment Before the Dep't of Health & Human Servs. Regarding the 21st Century Cures Act: Interoperability, Information Blocking, and the ONC Health IT Certification Program (2019), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-department-health-human-services-regarding-21st-century-cures-act-interoperability/v190002_hhs_onc_info_blocking_staff_comment_5-30-19.pdf; Brief for the United States and the *License to Compete: Occupational Licensing and the State Action Doctrine: Hearing Before the S. Comm. on the Judiciary, Subcomm. On Antitrust, Competition Policy, and Consumer Rights*, 114th Cong. 1–2 (2016), https://www.ftc.gov/public-statements/2016/02/prepared-statement-federal-trade-commission-license-compete-occupational; Fed. Trade Comm'n as *Amici Curiae* Supporting Plaintiffs-Appellees, Teladoc, Inc. v. Texas Medical Board, (5th Cir. Dec. 9, 2016) (Case: 16-50017).

addition to the attached Policy Paper, FTC staff have submitted written comments analyzing the likely competitive effects of proposed APRN regulations in various states, and observing that removing excessive supervision requirements can achieve significant consumer benefits.[18] Several such comments have focused, in particular, on APRN prescribing authority, as the ability to write prescriptions is one of the defining criteria for independent APRN practice.[19]

II. H.B. 2412

The Bill would, as noted in your letter, amend Kansas statutes to permit a licensed and experienced APRN to "prescribe, procure and administer prescription drugs and controlled substances in schedules II through V pursuant to applicable federal and state laws,"[20] striking the current requirement that this be done "pursuant to a written protocol" established with a Kansas licensed physician.[21] An APRN with "less than 4,000 hours of licensed active practice as an advanced practice registered nurse under a collaborative relationship with a physician" would not be able to prescribe drugs independently until he or she completed a "program of transition to full practice as an advance practice registered nurse," under rules promulgated by the Board of Nursing.[22]

While proposing to remove the requirement of a formal written protocol with a particular Kansas licensed physician, the Bill would not otherwise alter the substantive licensing

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[18] *See, e.g.*, FTC Staff Comment to the Hon. Kent Leonhardt, Senator, Senate of West Virginia, Concerning the Competitive Impact of WV Senate Bill 516 on the Regulation of Certain Advanced Practice Registered Nurses (Feb. 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf; Letter from FTC Staff to the Hon. Jenny A. Horne, Representative, S.C. House of Representatives, regarding House Bill 3508 and 3078 on Advanced Practice Registered Nurse Regulations (Nov. 2, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-south-carolina-representative-jenny.horne-regarding-house-bill-3508-3078-advanced-practice-registered-nurse-regulations/151103scaprn.pdf; Letter from FTC Staff to the Hon. Jeanne Kirkton, Representative, Mo. House of Representatives (Apr. 21, 2015), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-representative-jeanne-kirkton-missouri-house-representatives-regarding-competitive/150422missourihouse.pdf (regarding collaborative practice arrangements between physicians and APRNs); Letter from FTC Staff to the Hon. Kay Khan, Representative, Mass. House of Representatives (Jan. 17, 2014), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-massachusetts-house-representatives-regarding-house-bill-6-h.2009-concerning-supervisory-requirements-nurse-practitioners-nurse-anesthetists/140123massachusettnursesletter.pdf (regarding supervisory requirements for nurse practitioners and nurse anesthetists); Letter from FTC Staff to Theresa W. Conroy, Representative, Conn. House of Representatives (Mar. 19, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-honorable-theresa-w.conroy-connecticut-house-representatives-concerning-likely-competitive-impact-connecticut-house-bill/130319aprnconroy.pdf (APRNs).

[19] *See, e.g.*, FTC Staff Comment to the Hon. Kent Leonhardt, Senator, Senate of West Virginia, *supra* note 18; 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), http://www.ftc.gov/os/2011/05/V110007texasaprn.pdf.

[20] Proposed K.SA.. § 65-1130(d)(1).

[21] *Id.*

[22] *Id.* at § 65-1130(h)(1)-(2).

requirements for Kansas APRNs, and the Bill would not otherwise alter the scope of practice of APRNs, according to their education and training, or according to other Kansas and federal laws and regulations.

III. LIKELY IMPACT OF THE BILL

a. Excessive Restrictions on Advanced Practice Nursing Raise Competition Concerns That May Impact Access, Cost, and Quality of Care

FTC staff recognize that certain professional licensure requirements and scope-of-practice restrictions may protect patients.[23] Consistent with patient safety, however, we have urged regulators and legislators to consider that independent practice by APRNs may facilitate greater competition, which also may benefit patients. If APRNs are better able to practice to the full extent of their education, training, and abilities, and if institutional health care providers are better able to deploy APRNs as needed, health care consumers are likely to benefit from improved access to health care, lower costs, and additional innovation.

The ability to write prescriptions is one of the defining criteria for independent APRN practice.[24] In brief, APRNs cannot practice independently if they cannot write prescriptions independently. Twenty-two states and the District of Columbia now permit independent prescribing by advanced practice nurses.[25] As the IOM observes, studies suggest that APRNs are safe and effective in writing prescriptions, that APRNs and MDs have comparable prescribing patterns, and that patients of APRNs and MDs have comparable outcomes when APRNs can prescribe medicines independent of physician supervision.[26]

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[23] For example, licensure requirements or scope-of-practice restrictions may sometimes offer an efficient response to certain types of market failure arising in professional services markets. *See* CAROLYN COX & SUSAN FOSTER, FED. TRADE COMM'N, BUREAU OF ECONOMICS, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 5–6 (1990), http://www.ftc.govibe/consumerbehavior/docs/reports/CoxFoster90.pdf.

[24] *See, e.g.*, IOM FUTURE OF NURSING REPORT, *supra* note 10, at 100, 332; FTC Staff Louisiana APRN Comment, *supra* note 18, at 3, 5; West Virginia Testimony, *supra* note 18, at 3-6.

[25] *See supra* note 11.

[26] IOM FUTURE OF NURSING REPORT, *supra* note 10, at 98-99, 108 (citing, *e.g.*, M.O. Mundinger et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: A randomized Trial*, 283 JAMA 59 (2000) (comparing outcomes for 1316 ambulatory care patients randomly assigned to APRN and MD primary care providers, where APRNs had "same authority to prescribe, consult, refer, and admit patients," and finding no significant difference in patients' health status or physiologic test results); Lenz et al., *Primary Care Outcomes in Patients Treated by Nurse Practitioners or Physicians: Two-year Follow-up*, 61 MED. CARE RES. REV. 332 (2004) (Two-year follow-up data for Mundinger et al. consistent with preliminary results); Ann B. Hamric et al., *Outcomes Associated with Advanced Nursing Practice Prescriptive Authority*, 10 J. Amer. Acad. Nurse Practitioners 113 (1998) (safety and effectiveness in study of 33 APRNs in 25 primary care sites); Pamela Venning et al., *Randomised Controlled Trial Comparing Cost Effectiveness of General Practitioners and Nurse Practitioners in Primary Care*, 320 BRIT. MED. J. 1048, 1050 (2000) ("There was no significant difference in patterns of prescribing or health status outcome. . . ."); *see also* FTC STAFF POLICY PAPER, *supra* note 4, at 37-38. FTC staff are not aware of any empirical evidence supporting a contrary contention that patient harms or risks are particularly associated with APRN prescribing.

Section III of the FTC staff Policy Paper discusses in detail the potential competitive harms from overly restrictive APRN supervision requirements, including the types of mandatory collaborative practice agreements that roughly half the states now require.[27] The Policy Paper analyzes these competitive harms as potential consequences of market-wide regulations, and the potential benefits of policy reform as those likely to follow the repeal or retrenchment of such regulatory constraints. The Policy Paper analyzes three basic issues of particular relevance to the Proposed Rule.

First, regulatory constraints on APRN practice limit the ability of APRNs to expand access to primary care services and to ameliorate both current and projected health care workforce shortages. The United States faces a substantial and growing shortage of physicians, especially in primary care.[28] As a result, many Americans may face limited access to basic health care services, particularly in poor or rural areas.[29] Due to physician shortages, there are approximately 6,900 primary care health professional shortage areas ("HPSAs") across the United States.[30] Kansas has many such areas, ranging over large parts of the state.[31] For example, as noted above, 66 Kansas counties are Governor-Designated Medically Underserved Areas,[32] based on assessed shortages of primary care physicians.[33] Such areas must be both rural (located outside a U.S. Census Bureau urbanized area) and underserved; that is, they must be either federally designated health professional shortage areas or medically underserved areas or Kansas designated shortage areas.[34]

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[27] *See* FTC STAFF POLICY PAPER, *supra* note 4, at 18-38. Somewhat more than half of the states still require some form of physician supervision for APRNs, although the particulars of those requirements vary state-by-state. *Id.* Requirements also vary somewhat for different categories of APRNs. According to the National Council of State Boards of Nursing, under slightly different criteria than those for the VA's "full practice authority," 22 states and the District of Columbia permit "independent practice" by CRNAs, Nat'l Council State Bds. Nursing, CRNA Independent Practice Map, https://www.ncsbn.org/5404.htm, and 25 states and the District of Columbia permit "independent practice" by CNMs, Nat'l Council State Bds. Nursing, CRNA Independent Practice Map, https://www.ncsbn.org/5405.htm (last visited June 20, 2016).

[28] FTC STAFF POLICY PAPER, *supra* note 4, at 20.

[29] *Id.* at 21; IOM FUTURE OF NURSING REPORT, *supra* note 10, at 106–07 ("Expanding the scope of practice for NPs is particularly important for the rural and frontier areas of the country. Twenty-five percent of the U.S. population lives in these areas; however, only 10 percent of physicians practice in these areas (NRHA, 2010). People who live in rural areas are generally poorer and have higher morbidity and mortality rates than their counterparts in suburban and urban settings, and they are in need of a reliable source of primary care providers (NRHA, 2010).").

[30] U.S. Dep't Health & Human Servs., Health Resource & Servs. Admin., HRSA Data Warehouse Fact Sheet Maps FY 2018 (indicating 6,890 primary care HPSAs), https://data.hrsa.gov/maps/fact-sheet-maps/ (last visited Dec. 9, 2019).

[31] Under federal criteria, 80 Kansas counties either qualify as Geographic health professional shortage areas (HPSAs) or comprise population HPSAs. Kansas Dep't Health & Environment, 2018 Health Professional Underserved Area Report, app. C, 24 (2019), http://www.kdheks.gov/olrh/download/2018_Underserved_Areas_Report.pdf; *see also* Health Resources & Servs. Admin., data.hrsa.gov, Find Shortage Areas, https://data.hrsa.gov/tools/shortage-area (searchable database for health professional shortage areas and medically underserved areas, by state or county).

[32] *See* text accompanying note 7, *supra*.

[33] *See* text accompanying note 8, *supra*.

[34] *Id.*

Expanded APRN practice is widely regarded as a key strategy to alleviate such provider shortages, especially in medically underserved areas and for medically underserved populations.[35] Nationally, APRNs already "make up a greater share of the primary care workforce in less densely populated areas, less urban areas, and lower income areas, as well as in HPSAs."[36]

Second, legal or regulatory hurdles to APRN practice may raise the costs of APRN services, thereby reducing supply and further diminishing access to basic primary care. APRNs tend to provide care at lower cost than physicians.[37] But "collaborative practice" or formal "protocol" requirements may add additional costs to those services. Both patients and third-party payors are harmed to the extent that higher costs are passed along as higher prices.[38] In contrast, when such requirements are reduced, the supply of professionals willing to offer APRN services at any given price is likely to increase. In underserved areas and for underserved populations, the benefits of expanding supply are clear: consumers may gain access to services that otherwise would be unavailable.[39] Even in well-served areas, a supply expansion tends to lower prices and drive down health care costs.[40]

Third, "rigid supervision requirements may impede, rather than foster, development of effective models of team-based care."[41] Health care providers that employ or contract with

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[35] *See, e.g.*, IOM FUTURE OF NURSING REPORT, *supra* note 10, at 27–28; NAT'L GOVERNORS ASS'N, NGA PAPER: THE ROLE OF NURSE PRACTITIONERS IN MEETING INCREASING DEMAND FOR PRIMARY CARE 11 (2012), http://www.nga.org/files/live/sites/NGA/files/pdf/1212NursePractitionersPaper.pdf [hereinafter NAT'L GOVERNORS ASS'N, NGA PAPER]. We do not mean to suggest that reforming APRN scope-of-practice restrictions is a panacea for primary care access problems. Rather, reducing undue restrictions on APRN scope of practice can be one significant way to help ameliorate existing and projected access problems. [undue hyperlink on highlighted part]

[36] FTC STAFF POLICY PAPER, *supra* note 4, at 25.

[37] *Id.* at 28. For example, a study conducted for the Commonwealth of Massachusetts by the RAND Corporation suggests concrete savings that might be associated with expanded APRN (and PA) scope of practice, due to the 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_TR733.pdf (describing conditions for upper and lower bound estimates and projections).

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

[39] "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 10, 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_TR733.pdf; NAT'L GOVERNORS ASS'N, NGA PAPER, *supra* note 35.

[40] The National Governors Association recognized the impact of this supply expansion in its NGA PRIMARY CARE PAPER, *supra* note 39.

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

APRNs typically develop and implement their own practice protocols, hierarchies of supervision, and models of team-based care to promote quality of care, satisfy their business objectives, and comply with regulations. Collaboration between APRNs and physicians is common in all states, including those that permit APRNs to practice independently.[42] Most APRNs work for institutional providers or physician practices with established channels of collaboration and supervision, and even "independently" practicing APRNs typically consult physicians and refer patients as appropriate.[43]

Moreover, new models of collaboration are an important area of innovation in health care delivery. Proponents of team-based care have recognized the importance of this innovation, given the myriad approaches to team-based care that may succeed in different practice settings.[44] Rigid collaborative practice or protocol agreement requirements "can arbitrarily constrain this type of innovation, as they can impose limits or costs on new and beneficial collaborative arrangements, limit a provider's ability to accommodate staffing changes across central and satellite facilities or preclude some provider strategies altogether."[45] FTC staff have reviewed reports from expert health agencies as well as the published academic literature, but are unaware of evidence that statutory practice agreement requirements are needed to achieve the benefits of team-based health care.

The competitive impact of unnecessary APRN regulations is concerning in light of evidence that independent practice--including independent prescribing--by APRNs might offer substantial benefits to Kansas health care consumers. As noted above, the competition issues analyzed in the FTC staff policy paper reinforce health policy findings and recommendations of expert bodies such as the IOM. For example, a 2011 IOM report identifies a key role for APRNs in improving health care delivery, while expressing concern about undue restrictions on APRN prescribing and practice.[46] Based on a rigorous examination of APRN practice issues, the IOM found that "[r]estrictions on scope of practice . . . have undermined [nurses'] ability to provide and improve both general and advanced care."[47] Similarly, in 2012, the National Governors Association ("NGA") reported on APRNs' potential to address increased demand for primary care services, particularly in historically underserved areas.[48] The NGA report noted the high

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[42] Regarding diverse practice settings and collaboration, see IOM FUTURE OF NURSING REPORT, *supra* note 10, 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/VSRT-Team-Based-Care-Principles-Values.pdf (IOM-sponsored inquiry into collaborative or team-based care).

[43] 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-files/Resources/2/cnf20120810.pdf.

[44] *Id.* at 31 (citing Pamela Mitchell et al., *supra* note 42).

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

[46] *See generally* IOM FUTURE OF NURSING REPORT, *supra* note 10 (especially Summary, 1-15; 99 - 102).

[47] *Id.* at 4.

[48] National Governors Association, *The Role of Nurse Practitioners in Meeting Increasing Demand for Primary Care* (Dec. 20, 2012), http://www.nga.org/cms/home/nga-center-for-best-practices/center-divisions/page-health-

quality of primary care services provided by APRNs, who "may be able to mitigate projected shortages of primary care services."[49]

Finally, as noted above, the Bill would require a period and program of transition to independent prescribing for APRNs who have "less than 4,000 hours of licensed active practice as an advanced practice registered nurse.[50] We are not aware of an evidentiary basis for these particular transition requirements for APRNs who already are licensed and otherwise qualified to practice. For that reason, we query whether a more streamlined path to independent prescribing would not provide adequate assurances of patient safety at lower cost to Kansas competition and consumers; and we recommend that the legislature compare the experience of states that do not require such transition programs[51] with states that do.[52] Still, we believe that the main provision of the Bill, providing a path to independent prescribing by APRNs, has the potential to confer substantial benefits on Kansas health care consumers.

b. Regulatory Oversight of APRN Prescribing by the Board of Healing Arts Would Raise Additional Competition Concerns

Your letter notes concern about a proposed amendment to the Bill that would assign regulation of APRN prescribing to the "physician-controlled Kansas Board of Healing Arts rather than the Kansas Board of Nursing," which now regulates APRN prescribing.[53] Such an amendment would raise concerns about potential biases and conflicts of interest. The IOM has argued that common restrictions on independent APRN practice and prescribing are not evidence-based, and that historically entrenched forms of training and care delivery, dated or erroneous beliefs about the training or performance of APRNs, and professional bias are factors in physician opposition to regulatory reform.[54]

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division/col2-content/list---health-left/list-health-highlight/content-reference-2@/the-role-of-nurse-practitioners.html [hereinafter NGA, *Role of Nurse Practitioners*].

[49] *Id.* at 11.

[50] *Supra* note 22.

[51] *See, e.g.*, N.H. Rev. Stat. § 326-B:11(III).

[52] *See, e.g.*, W. Va. Code § 30-7-15b(e)(1) (requiring three years of "collaborative practice").

[53] *See supra* note 1. We note that the 15 members of the Board of Healing Arts comprise 5 medical doctors (M.D.s), 3 osteopathic doctors (D.O.s), 3 chiropractic doctors (D.C.s), 1 podiatric doctor (D.P.M.), and 3 public members. K.SA.. §§ 65-2812 - 65-2813. The Board does not appear to include any APRN members. Kansas Bd. of Healing Arts, About the Board, Members, http://www.ksbha.org/aboutboard/boardmembers.shtml (last checked Dec. 10, 2019).

[54] IOM FUTURE OF NURSING REPORT, *supra* note 10, at 107-14; Barbara J. Safriet, *Federal Options for Maximizing the Value of Advanced Practice Nurses in Providing Quality, Cost-Effective Health Care*, in IOM FUTURE OF NURSING REPORT, *supra* note 10, at 451-57 ("I want to be clear that I mean to attribute no malice or ill will to individual actors in the scope-of-practice battles. The problems have become structural and cultural, and we all—physicians included—pay a huge price for the consequences, measured in extra real dollars spent on health care, in lack of access to competent care, and in the constant antagonism among health care professionals who would be better served by working cooperatively to provide optimal care.").

FTC staff recognize Kansas state prerogatives in designing regulatory oversight for Kansas health care professionals; and we defer to the legislature on how best to incorporate expert input--including physician input--into its regulatory process. At the same time, we strongly suggest that it may be problematic to have independent regulatory boards dominated by medical doctors and doctors of osteopathy serve as regulators of APRN prescribing. As the Commission has noted in Congressional testimony about occupational regulation more generally:

> From a competition standpoint, occupational regulation can be especially worrisome when regulatory authority is delegated to a board composed of members of the occupation it regulates. The risk is that the board will make regulatory decisions that serve the private economic interests of its members and not the policies of the state. These private interests may lead to the adoption 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.[55]

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 board's ability to insulate itself against allegations of anticompetitive conduct.[56] 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 . . . ."[57]

IV. CONCLUSION

FTC staff support policy reforms, such as those in H.B. 2412, to remove undue barriers to the provision of health care services by qualified and licensed APRNs. We strongly believe that independent APRN prescribing authority can help improve access to care, contain costs, and expand innovation in health care delivery.

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[55] Prepared Statement of the Fed. Trade Comm'n on License to Compete: Occupational Licensing and the State Action Doctrine Before the S. Comm. on the Judiciary, 114th Cong. (Feb. 2, 2016); *see also* Prepared Statement of the Fed. Trade Comm'n on Competition and the Potential Costs and Benefits of Professional Licensure Before the H. Comm. on Small Bus., 113th Cong. (2014).

[56] N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101 (2015). In that case, the Court clarified the conditions under which an independent regulatory board could (or could not) raise a defense to federal antitrust allegations based on the "State Action Doctrine," and did not address the policy merits of North Carolina's statutes governing that regulatory board. However the Court's competition concerns about one group of professionals excluding another based on financial incentives are directly analogous to concerns about empowering physicians to bar or regulate APRN prescribing.

[57] *Id.* at 1111.

Respectfully submitted,

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Enclosure