Reforming America's Healthcare System Through Choice and Competition
Statements Relevant to the PA Profession

In December 2018, a joint report was issued by the U.S. Departments of Health and Human Services, Treasury, and Labor examining recommendations to improve healthcare marketplace competition. The report, titled "Reforming America's Healthcare System Through Choice and Competition," includes several recommendations to improve PA practice and remove barriers to PA licensure. Below are selected quotes and recommendations from the report, with the Administration's citations when appropriate.

General:

- "Health care markets could work more efficiently and Americans could receive more effective, high-value care if we remove and revise certain federal and state regulations and policies that inhibit choice and competition." (Page 1 – Letter).

The Movement of Physicians from Private to Group Practice:

- "Hospitals have increasingly been acquiring physician practices. One study reported that the share of physician practices in the United States owned by hospitals doubled over the period 2002-2008.[1] Another study examined the effect of the acquisition of physician practices by hospitals on prices and expenditures over the period 2007-2013. It reported that hospitals acquired 10 percent of the physician practices in their sample during their sample period."[2] (Page 28).
- (Graphic): In 2010, 27.7% of primary care physicians worked for a hospital or healthcare system, 30.7% were part of a medical group, and 41.6% were in independent practice. In 2016, 43.5% of primary care physicians worked for a hospital or healthcare system, 21.2% were part of a medical group, and 35.3% were in independent practice.[3] (Page 28) (See Figure 1).
- "In its 2013 Report to Congress, the Medicare Payment Advisory Commission (MedPAC), an independent, non-partisan, Congressional support agency, similarly reported that while the number of physicians and dentists employed by hospitals was relatively constant from 1998 to 2003, it increased by 55 percent from 2003 to 2011."[4] (Page 29).

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[1] Baker L, Bundorf MK, Kessler DP. Vertical integration: hospital ownership of physician practices is associated with higher prices and spending. *Health Aff.* 2014;33(5):756-763.

[2] Capps C, Dranove D, Ody C. The effect of hospital acquisitions of physician practices on prices and spending. Working Paper. 2017. Available at http://www.ipr.northwestern.edu/publications/papers/2015/ipr-wp-15-02.html. Accessed August 22, 2018.

[3] Mathews, Anna Wilde. Behind Your Rising Health-Care Bills: Secret Hospital Deals That Squelch Competition. September 18, 2018. https://www.wsj.com/articles/behind-your-rising-health-care-bills-secret-hospital-deals-that-squelch-competition-1537281963

[4] MedPAC. Report to Congress: Medicare and the health care delivery system. Policy Brief. June 2013. http://www.ipr.northwestern.edu/publications/papers/2015/ipr-wp-15-02.html. Accessed August 22, 2018.

- "[A] survey by the Medical Group Management Association found a 75 percent increase in the employment of doctors by hospitals between 2000 and 2012."[5] (Page 29).

Benefits of Removing Barriers to PA Practice:

- "Government policies that reduce the available supply of qualified healthcare service providers or the range of services they may safely offer can increase the prices paid for healthcare services, reduce access to care, and suppress the benefits of competition and innovation in healthcare delivery. Such regulations can also unnecessarily limit the types or locations of providers authorized to practice or the range of services they can provide." (Page 30).
- "[…] [P]hysician assistants (PAs),[6] […] can safely and effectively provide some of the same healthcare services as physicians, in addition to providing complementary services." (Page 33).
- "[…] [R]esearch suggests that allowing allied health professionals to practice to the full extent of their abilities is not a zero sum game for other medical professionals, and may actually improve overall health system capacity."[7] (Page 34).
- "[…] [R]igid 'collaborative practice agreement' requirements can impede collaborative care rather than foster it because they limit the ability of healthcare professionals to adapt to varied healthcare demands, thereby constraining provider innovation in team-based care."[8] (Page 35 – note this citation relates only to APRNs).
- […] [M]any states have granted full practice authority to APRNs, but there is significant room for improvement in other states and for other professions." (Page 35).
- "Recommendations […]
    - States should consider changes to their scope-of-practice statutes to allow all healthcare providers to practice to the top of their license, utilizing their full skill set.
    - The federal government and states should consider accompanying legislative and administrative proposals to allow non-physician […] providers to be paid directly for their services where evidence supports that the provider can safely and effectively provide that care.
    - States should consider eliminating requirements for rigid collaborative practice and supervision agreements between physicians […] and their care extenders (e.g., physician assistants […]) that are not justified by legitimate health and safety concerns." (Page 36).

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[5] Kocher R, Sahni NR. Hospitals' race to employ physicians – the logic behind a money-losing proposition. *N Engl J Med.* 2011;364(19):1790-1793.

[6] U.S. Congress, Office of Technology Assessment. *Nurse Practitioners, Physician Assistants, and Certified Nurse-Midwives: A Policy Analysis.* Health Technology Case Study 37. OTA-HCS-37. Washington, DC: U.S. Government Printing Office; December 1982:39. https://www.princeton.edu/~ota/disk2/1986/8615/8615.PDF. Accessed August 22, 2018.

[7] Improving efficiency in the healthcare system: removing anti-competitive barriers for advanced practice registered nurses and physician assistants. The Hamilton Project. Policy brief 2018-08. June 2018.

[8] Dep't Veterans Affairs, Economic Impact Analysis for RIN 2900-AP44, Advanced Practice Registered Nurses, attachment 1, 20 (Nov. 9, 2016).

Licensure, Competition, and Regulatory Boards:

- "Government rules restrict competition if they keep healthcare providers from practicing to the 'top of their license' – i.e., to the full extent of their abilities, given their education, training, skills, and experience, consistent with the relevant standards of care. Such rules, including restrictions on the appropriate use of telehealth technologies, unnecessarily limit the types or locations of providers authorized to practice, or the range of services they can provide, in contrast to regulations tailored to address specific and non-speculative health and safety concerns." (Page 30).
- "… [Scope of practice] restrictions limit provider entry and ability to practice in ways that do not address demonstrable or substantial risks to consumer health and safety."[9] (Page 31).
- When state regulators impose excessive entry barriers and undue restrictions on [scope of practice] for particular types of providers, they often are not responding to legitimate consumer protection concerns. There is a risk that healthcare professionals with overlapping skill sets will seek these restrictions; they view [scope of practice] restrictions as an easy, state-sanctioned opportunity to insulate themselves form competition."[10] (Page 32).
- The risk of anti-competitive harm may be even greater when the regulatory board that imposes [scope of practice] restrictions on one occupation is controlled by members of another, overlapping occupation that provides complementary or substitute services,[11] and the board members are themselves active market participants with a financial stake in the outcome."[12] (Page 32).
- "State-based licensing requirements, by their nature, inhibit provider mobility.[13] These requirements add time and expense when healthcare providers seek to move or work across

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[9] Occupational licensing: a framework for policy makers. U.S. Department of the Treasury, Council of Economic Advisors, and the Department of Labor. July 2015, at 12-13; Cox C, Foster S. Bureau of Economics, Federal Trade Commission. The Costs and Benefits of Occupational Regulation, at 3. 1990. http://www.ramblemuse.com/articles/cox_foster.pdf. Accessed August 22, 2018. Policy perspectives: competition and the regulation of advanced practice nurses. Federal Trade Commission. March 7, 2014, at 14-15. https://www.ftc.gov/reports/policy-perspectives-competition-regulation-advanced-practice-nurses. Accessed August 22, 2018.

[10] Stigler GJ. The theory of economic regulation. *Bell J Econ Man Sci.* 1971 Spring;2(1):18-20. Kleiner MM. Occupational licensing. *J Econ. Persp.* 2000;14:13-14. Kleiner MM, Krueger AB. Analyzing the extent and influence of occupational licensing on the labor market. 31 *J Lab Econ.*2013 Apr;31 S1, Part 2:73,75.

[11] Occupational licensing: a framework for policy makers. U.S. Department of the Treasury, Council of Economic Advisors, and the Department of Labor. July 2015, at 30. https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf. Accessed August 25, 2018; Gilman DJ, Fairman J. Antitrust and the future of nursing: federal competition policy and the scope of practice. *Health Matrix.* 2014;24:157.

[12] *License to Compete: Occupational Licensing and the State Action Doctrine, Hearing Before the S. Comm. On the Judiciary, Subcomm. On Antitrust, Competition Pol'y and Consumer Rights,* 114th Cong., 1 (Feb. 2, 2016); *c.f. N.C. State Bd. Of Dental Exam'rs v. FTC,* 135 S. Ct 1101, 1114 (2015).

[13] Licensing rules are almost always state-based. See, e.g., Dent v. West Virginia, 129 U.S. 114 (1889) (upholding the authority of the State of West Virginia to license physicians); Health Resources and Services Administration, U.S. Department of Health and Human Services. Telehealth licensure report. Report 111-66. Special Report to the Senate Appropriations Committee (Requested by Senate). 2010. ("For over 100 years, health care in the United States has primarily been regulated by the states. Such regulation includes the establishment of licensure

state lines. Markets cannot be as responsive to economic change when workers cannot easily move to meet the demand for their services.[14] (Page 36).

- "State-based licensing also often inhibits delivery of healthcare services across state lines by making it more difficult for qualified healthcare professionals licensed in one state to work in another state, even though most healthcare providers complete nationally certified education and training programs and sit for national qualifying exams."[15] (Page 37).
- "Appropriate standards of care do not differ from state to state. Yet, even when a profession's underlying standards are national in scope, and when state licensing requirements are similar throughout the United States, the process of obtaining a license in another state is often slow, burdensome, and costly."[16] (Page 37).

Payment/Reimbursement:

- "For patients to realize the benefits of changes to state [scope of practice] restrictions, state Medicaid programs would need to reimburse allied health professionals independently for their services." (Page 34).

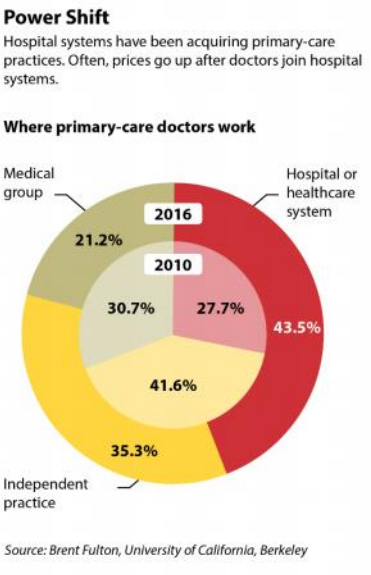
requirements and enforcement standards of practice for health providers, including physicians, nurses, pharmacists, mental health practitioners, etc.")

[14] See, e.g., Occupational Licensing: Regulation and Competition: Hearing Before the Subcomm. on Regulatory Reform, Commercial and Antitrust Law of the House Comm. on the Judiciary, 115th Cong. 1, 8-9 (2017) (statement of Maureen K. Ohlhausen, Acting Chairman, Federal Trade Commission). https://www.ftc.gov/system/files/documents/public_statements/1253073/house_testimony_licensing_and_rbi_act_sept_2017_vote.pdf. Accessed August 22, 2018; Occupational licensing: a framework for policy makers. U.S. Department of the Treasury, Council of Economic Advisors, and the Department of Labor. July 2015, at 12-16. https://obamawhitehouse.archives.gov/sites/default/files/docs/licensing_report_final_nonembargo.pdf. Accessed August 25, 2018.

[15] See, e.g., Health Resources & Services Administration, U.S. Department of Health & Human Services. Special Report to the Senate Appropriations Committee, Telehealth Licensure Report, Requested by Senate Rep't 111-66 (2010), at 9, ("The basic standards for medical and nursing licensure have become largely uniform in all states. Physicians and nurses must graduate from nationally approved educational programs and pass a national medical and nursing licensure examination.")

[16] See, e.g., American Medical Association. Obtaining a medical license. http://www.amaassn.org/ama/pub/education-careers/becoming-physician/medical-licensure.page. Accessed August 22, 2018. ("The process of obtaining a medical license can be challenging and time consuming…. Physicians seeking initial licensure or applying for a medical license in another state should anticipate delays due to the investigation of credentials and past practice as well as the need to comply with licensing standards."); U.S. Department of the Treasury and U.S. Department of Defense, Supporting our military families: best practices for streamlining occupational licensing across state lines. February 2012:12-13. http://archive.defense.gov/home/pdf/Occupational_Licensing_and_Military_Spouses_Report_vFINAL.PDF. Accessed August 22, 2018. ("Nurses moving across state lines must apply for licensure by endorsement and pay any applicable fees.")

Figure 1:



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