

The Affordable Care Act, the FTC and the Independent Practice of Nurses



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Although the intention of the Affordable Care Act (ACA) is to improve access to primary care for everyone, it also will increase the need for primary care practitioners. If Americans are going to achieve better health through preventive care and early intervention, there has to be a person properly trained and licensed to deliver and coordinate their care.

This necessity for more “boots on the ground” is why the ACA supports nursing in many ways, including increased student loan availability;¹ advanced nursing education grants that focus upon nurse practitioner and nurse midwifery programs;² as well as student loan forgiveness, scholarships and loans to accredited nursing schools to foster the increase of the nursing faculty nationally.³

More controversially, the vision of the ACA seeks to do more than increase the nursing population, for the law alters how nurses—specifically advanced practice nurses (APNs)—will deliver patient care. No longer will APNs be providing patient care under a physician’s direction; in the post-ACA world, nurses—at least in some settings—will act as a patient’s primary provider, fully independent of any physician supervision.

This concept of an expanded and less physician-centric, health care workforce will potentially be encouraged by a developing court case that was accepted on March 3rd for review by the U.S. Supreme Court. While on the surface it may appear to be unrelated, the outcome of *North Carolina Board of Dental Examiners v. Federal Trade Commission (FTC)*⁴ may have far-reaching implications for the independent practice of nurses in general and, specifically, the ability of state medical boards to limit the scope of their practice.

The confluence of the ACA and the FTC will make 2014 a pivotal year in answering the decades-old questions of what role nursing will play in the health care delivery system of the future, and to what extent will physicians be able to regulate the practice of medicine?

Regulating medicine and nursing

In every state, the role of regulating medicine lies with that state’s government through a medical board that is usually appointed by the governor under that state’s authorizing legislation (e.g., Medical Practice Act).⁵

A medical board’s core roles are to determine, for that state, what constitutes the practice of medicine, to issue licenses to people educated and prepared for the practice of medicine as per the board’s regulations, and to discipline licensed individuals who fail to meet those standards, up to and including revocation of licensure.

In regulating the practice of medicine, each medical board defines the “scope of practice” of medicine, denying nonphysicians from practicing without that licensure. Similarly, every state has a board of nursing that regulates the practice, licensure and policing of nursing within a state and the “scope of practice” of nursing, which is—again—within the purview of legally licensed nurses in the state.⁶ Protection of the public’s health, safety and welfare is the *sine qua non* of all medical and nursing boards.

Another important division of the emerging health care workforce is, of course, physician assistants (PAs) who also are increasingly involved in direct patient care. The designation, created with the first class at Duke University in 1965, was founded by a physician with significant input and support from the medical community.⁷

Although PAs are a recognized, licensed profession with their own state regulatory boards, they remain closely connected to physicians and organized medicine.⁸ The unique history and tradition of nursing, however, sets it apart as a potentially separate, parallel profession to physicians.

For at least five decades, each state has weighed how to best utilize the growing number of nurses with advanced training and clinical abilities. Nurse anesthesia⁹ and midwifery¹⁰

are nursing specialties that date back to the 1930s and 1940s. In the 1960s, advanced training in nursing became far more visible to the public with the first nurse practitioner program developed in 1965.¹¹

Clinical nurse specialists added another avenue to advanced nursing beginning in the 1980s.¹² These four areas of nursing practice, although diverse, are collectively known as advance practice nurses (APNs), and are all regulated through each state's nursing board.

As these designations grew, however, they increasingly became a focus of medical board attention, as each state had to determine over the years under what circumstances APNs would be allowed to deliver what is defined as medical care (e.g., diagnosis and treatment of diseases and medical conditions).

Traditionally, all states allowed APNs to practice in a setting that provided direct supervision by a physician, although the extent of that supervision has differed among states increasingly over the years. Four states with large rural populations established independent nursing practice as early as the 1980s,¹³ and other states—particularly where the primary care shortage was most pronounced—followed suit in the 1990s.

The expansion of Medicaid through the ACA further added to the list; as of July last year APNs are practicing without physician supervision in 17 states,¹⁴ although the Institute of Medicine—using a different interpretation of specific statutory language—would expand the list to 19 states.¹⁵ Other states continue to look at the development of independent practice as a means to increase primary care access to their population.¹⁶

In the remaining states, still well over half of the country, the delineation between the practice of medicine and the allowable scope of practice of nursing is an active battle, with 527 different measures being introduced



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in state legislatures between 2011 and July 2013 collectively, according to the National Conference of State Legislatures.¹⁶ As many readers will know from personal experience, battles between physicians and APNs in most states have been prolonged, heated and emotional on both sides.

Independent nursing under the ACA

The ACA's provision for independent nursing practice (i.e., nurses diagnosing and treating patients without physician supervision) must be viewed from the perspective of the decades of debate on this same issue at each state's level.

Even if it could have done so (which is unlikely), the ACA does not interfere with each state lawfully addressing the delineation of the scope of practice for APNs for itself.

However, for those clinical settings that fall under the Public Health Service Act of 1944 (PHSA), the ACA allows for the expansion of nursing to include APN practice without physician supervision.¹⁷

For seven decades the federal government has offered health care services to underserved populations through health centers (serving 21.1 million patients in 2012) primarily in rural areas and in underserved populations such as the homeless, agricultural workers and residents of public housing.¹⁸

The U.S. Department of Health and Human Services (HHS) administers these centers through the Health Resources and Services Administration (HRSA), the primary federal agency addressing health care needs for the “uninsured, isolated or medically vulnerable.”¹⁹ The

ACA allocates funds to these centers through the Community Health Center Fund, which is in addition to the \$2 billion that was channeled to these community health clinics under the American Recovery and Reinvestment Act (ARRA) in 2009.

By amending the PHSA, the ACA created a new program authorizing the establishment of nurse-managed health clinics to serve these needy populations.²⁰ This legislative authority defines these clinics as:

“Nurse-practice arrangement, managed by advance practice nurses, that provides primary care or wellness services to underserved or vulnerable populations and that is associated with a school, college, university or department of nursing, federally qualified health center, or independent nonprofit health or social services agency.”²¹

Grants for the establishment of nurse-managed health clinics fell under a three-year program that allocated \$15 million for federal fiscal years 2010 through 2012; grants were awarded in 2010. The ability to extend a nurse-managed health clinic beyond 2013 was a requirement for grant receipt.²²

These are federal facilities under federal jurisdiction and evade the control of state legislation, regulations and boards. Independent nursing practices in selected federal facilities have existed within, but separate from, the scope of practice limitations that may exist in any state.

These parallel worlds would presumably continue indefinitely, were it not for the potentially seismic, recent case involving the FTC and the North Carolina Dental Board that is now bringing the scrutiny of the U.S. Supreme Court to the role of state regulatory bodies and how freely they can limit the professions under their jurisdiction.

The FTC and scope of practice

The case in point involves the regulation of teeth whitening and the role of the state dental licensing board. The North Carolina Dental Board, comprised of eight members—six of whom are practicing dentists and elected by their fellow dentists—determined that whitening teeth in kiosks, malls and spas constituted the unlicensed practice of dentistry, and ordered the vendors to stop offering whitening services (peroxide treatment sometimes enhanced by a special light).

This action was not unprecedented, for at least 25 other state dental boards have drawn the scope of dentistry along similar lines.²³ The FTC successfully challenged the orders as anticompetitive behavior in December 2011. Upon appeal, the U.S. Court of Appeals for the Fourth Circuit last May upheld the ruling,²⁴ and, this past March, the U.S. Supreme Court accepted the dental board’s request to hear the case.²⁵

At issue is whether the dental board, when prohibiting these teeth-whitening vendors, was acting in such a manner as to qualify for the “state action exemption” for antitrust analysis. This legal principle allows for states to impose what would otherwise be anticompetitive restraints in certain markets, if doing so is part of its governing.

The exception would clearly pertain to activities of a state legislative body or court; private individuals working within the context of a state activity (such as through a regulatory board) may also be protected from antitrust scrutiny if their activity is clearly within the boundaries of duties contemplated by the authorizing legislative body (known as the “clear articulation” requirement) and if the challenged activity occurred under state supervision (“active state supervision” requirement).

If people acting under auspices of the state take an action that fails to

meet those two requirements, they can be held liable under antitrust law just like any one else.

The FTC argued that the board—comprised largely of dentists who themselves offer teeth whitening—did not meet the requirements for the state action exemption and was not protecting the public from unsafe dental procedures. Rather, the FTC alleged that the board was merely reducing competition in their own field.

It is worth noting that the FTC is not arguing against professional boards per se, but in this case is questioning the composition of the board and its authority, its motives, and the degree of state supervision under which the board attempted to close down teeth-whitening services offered by non-dentists.²⁶

The application of this case to the regulation of medicine was obvious to the American Medical Association (AMA), joined by the American Osteopathic Association, the Federation of State Medical Boards, the American Society of Anesthesiologists and four state medical societies.²⁷

In a friend-of-the-court brief filed in conjunction with the request for certiorari (appeal) to the Supreme Court, the AMA stated: “If state licensing decisions are subject to invalidation by federal agencies with no particular expertise in the healing arts, then those federal agencies will become the final arbiters of matters of public safety, tasks that they are ill-equipped to perform.”²³

The concern is not the whitening of teeth, of course, but the impact of invalidating medical boards’ ability to limit the practice of medicine, in particular by mandating physician supervision of APNs.²³

The current North Carolina Dental Board challenge, therefore, goes straight to the heart of the ongoing state battles between the designated authorities on limiting the practice of medicine and those that argue for the independence of APNs. The decision

could go either way, but as of the time of this printing, the answer should be imminent, with the court's opinion expected in June.

If the U.S. Supreme Court overturns the lower court rulings, we will all return to the status quo of our particular state. If the opposite should happen, the ACA's vision of a newly independent class of health care practitioner will, in all likelihood, extend to all 50 states. An early summer news flash could diminish the powers of state medical boards, with physicians losing, simultaneously, the licensing battles across the country.

Conclusion

The reaction of organized medicine underscores the concern held by many that a Supreme Court opinion adverse to the North Carolina Dental Board will have repercussions for physicians across America, particularly in those states that still maintain a requirement for physician supervision of APNs.

More than that, however, if medical boards across the country are no longer able to define the scope of practice, many fear that the quality of care will erode into an unregulated world of "practitioners" of all feathers offering any and all "cures" without limitation.

However, taking a more measured response, the potential impact of the Supreme Court decision should be considered on the level of the profession at large as well as from an individual physician. As to the first, the call is for more professionalism, not abdication. Perhaps the distinction between medicine and nursing—at least in the arena of primary care—may be less distinct, yet this does not portend the end of medicine itself. It will be important to continue to protect the public's health, safety and welfare, while assuring the quality of care in all of our communities, regardless of where it is accessed. Physicians will not disappear; they will just find themselves on a more crowded playing field.

So what about the solo physician who finds himself in direct competition with an APN across the street?

Some argue the competition will be unfair, given the reduced reimbursement afforded the APN under the Balanced Budget Act of 1997, but why would unequal payment survive the parity of individual practice? There are already rumblings that independent APNs should be paid accordingly. Ironically, if the reimbursement disparity is erased, it will be to the advantage of the physician, because any cost-related competitive edge will also be eradicated.

The key to dealing with any negative impact from the Supreme Court decision this summer will be to focus on quality, patients and the health of our population. In every community, physicians need to be driven to achieve excellence of care for every person.

Physician leaders focused on quality and measurable outcomes can help lead the entire health care work force toward safe, efficient, and effective care for everyone, every day. Partnership will be essential. The landscape of health care as envisioned by the ACA is creating more need for physician leadership, not less; that is the possibility for medicine in the new post-ACA America.



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