Nurse Practitioners: The Value of Full Practice Authority

Spotlight: Pennsylvania, July 2015

The American health care market simultaneously faces two precarious trends: rising costs and a growing shortage of primary care providers. An aging population and millions of newly insured under the Affordable Care Act have increased demand growth, but supply growth has stalled as physicians retire and medical school graduates choose specialty careers over primary care. The nation faces a 20,400-physician shortage by 2020.[1] A growing number of key stakeholders have recommended expanding the role of nurse practitioners (NP) to help meet growing primary care gaps, but a number of states limit NPs' ability to practice to the full extent of their training and experience. Granting NPs full practice authority is one of the most effective steps for states to increase the supply of primary care providers while maintaining high-quality care and driving down healthcare costs.

PENNSYLVANIA

Pennsylvania's legislature is considering joining the states that allow NPs full practice authority. The state's primary care providers (PCP) are concentrated in its southeast and southwest regions, and nearly 35 percent of Pennsylvanians live in an area or population group with inadequate primary care access.[2] Low-supply areas, especially in the state's interior, face further pressure as demand grows. Even in Philadelphia, patient wait times for primary care appointments are up to 21 days, from just 9 days in 2009.[3]

Full Practice Authority would generate at least **$6.4 billion** in health care savings for PA over ten years

The state's primary care landscape suggests more patients—particularly those on Medicaid—are turning to NPs for primary care. Nationwide, NPs serve more diverse and underserved populations, including those in Health Professional Shortage Areas (HPSAs), than other PCPs.[4] NPs are also much more likely to treat the disabled and dual Medicare-Medicaid eligible patients.

INCREASING ACCESS

In early 2014, a Federal Trade Commission report warned that limits like collaboration agreement requirements that unnecessarily limit NP practice authority raise costs, reduce competition, and block consumer benefits.[5] Our analysis suggests that over 1,000 more NPs, roughly a 13 percent increase, would be practicing in Pennsylvania today had the state lifted practice restrictions last decade.[6] An increase of this size for primary care access would help satisfy growing unmet demand. It would also provide more convenient times and locations. For example, NPs often work in retail-based clinics, and other convenient forums, whereas physicians generally do not.[7]

Full Practice Authority =

13%
more Nurse Practitioners in Pennsylvania

Annual checkups **increase**

Emergency visits **decrease**

IMPROVING QUALITY

In assessing reform's effect on quality, studies yield two key takeaways. First, primary care from NPs is of comparable or superior quality to care by

physicians. Patient satisfaction also increases. Adults report a 13–15 percent increase in visit quality; children report gains of 17–27 percent.[8]

Second, overall health outcomes are better in states that have granted reform. Annual checkups go up and avoidable emergency room visits go down in those states.[9]

LOWERING COST

Pennsylvania is among the ten states that had the highest levels of per capita health care spending in 2009, the last year of available data.[10] Full practice authority addresses this concern by lowering the cost of primary care without sacrificing quality. Nationally, acute care from NPs is 20 percent less expensive than the same care by physicians.[11] Based on this alone, Pennsylvania would save $6.4 billion after the first ten years of reform.[12] And this estimate is conservative. Reform could produce additional savings on general medical examinations and well-baby visits, which would save healthcare consumers $12.7 billion over ten years. These savings directly translate to lower burdens on consumers, businesses, and public programs.

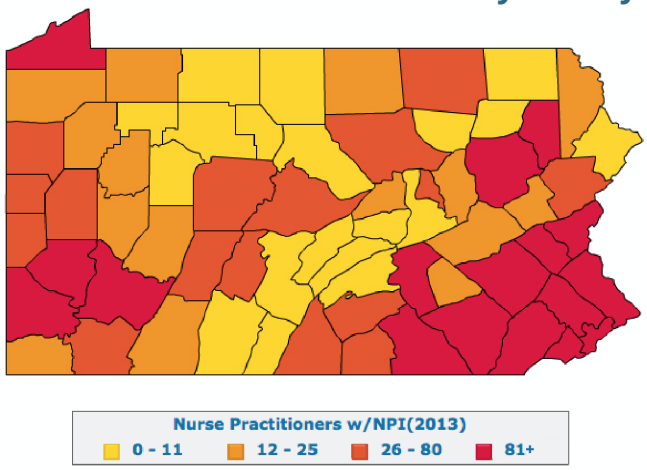
POLICY RECOMMENDATIONS

Pennsylvania should follow the lead of 21 other states and the District of Columbia and grant full practice authority to NPs. The existing barriers are unnecessary and weaken a key source of primary care. Removing these barriers is critical to ensuring access to high-quality care, managing health costs, and improving health for all Pennsylvanians.

Nurse Practitioners per 100,000 Residents by HSA in Pennsylvania

HSA #	Counties	Current	Reform
42	Allegheny, Armstrong, Beaver, Butler, Westmoreland, Indiana	83	93
139	Berks	53	60
858	Bradford, Sullivan, Susquehanna	95	107
57	Bedford, Blair, Cambria, Somerset	54	61
26	Centre, Clearfield, Jefferson	47	53
117	Crawford	45	51
43	Cumberland, Dauphin, Lebanon, Perry	73	83
125	Elk	57	65
880	Erie, Warren	77	87
872	Franklin, Fulton	37	42
47	Lackawanna, Wayne	70	79
140	Lancaster	59	67
129	Lawrence	48	54
84	Lehigh, Carbon, Monroe, Northampton	73	83
78	Luzerne, Columbia, Wyoming	41	47
44	Lycoming, Clinton	112	126
864	McKean, Cameron, Potter	40	45
918	Mercer	51	58
110	Mifflin, Huntingdon, Juniata	24	27
28	Philadelphia, Bucks, Chester, Montgomery, Delaware	104	118
876	Pike	12	13
8	Schuylkill, Montour, Snyder, Northumberland, Union	54	61
128	Tioga	70	79
52	Venango, Clarion, Forest	57	65
100	Washington, Fayette, Greene	57	65
868	York, Adams	59	67

Nurse Practitioners Numbers by County



*Numbers determined by National Provider Identification Number
Data Source: 2012–2013 Area Health Resource File, U.S. Dept. of Health and Human Services

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(Endnotes)

1. Dep't of Health & Human Serv., Projecting the Supply and Demand for Primary Care Practitioners Through 2020 26 (2013).
2. Kaiser Family Foundation, *Primary Care Health Professional Shortage Areas,* KFF.org (April 28, 2014), http://kff.org/other/state-indicator/primary-care-health-professional-shortage-areas-hpsas/.
3. Merritt Hawkins, Physician Appointment Wait Times 14 (2014).
4. Catherine M. DesRoches et al., *Using Medicare data to assess nurse practitioner-provided care,* 61Nursing Outlook 400, 403-04 (2013).
5. Fed. Trade Comm'n, Policy Perspectives: Competition and the Regulation of Advance Practice Nurses (March 2013).
6. *See* Patricia B. Reagan & Pamela Salsberry, *The effects of state-level scope-of-practice regulations on the number and growth of nurse practitioners*, 61 Nursing Outlook 392 (2013).
7. Morris M. Kleiner et al., *Relaxing Occupational Licensing Requirements: Analyzing Wages and Prices for a Medical Service* (Nat'l Bureau of Econ. Research Working Paper No. 19906, 2014).
8. *See id.*
9. *See* Jeffrey Tracynski & Victoria Udalova, *Nurse Practitioner Independence, Health Care Utilization, and Health Outcomes* (Univ. of Haw. Working Paper, 2013).
10. CMS, *Health Spending by State Residence*, 1991–2009, 1 Medicare & Medicaid Research Review 4 (2011).
11. *See* Christine E. Eibner et al., Controlling Health Care Spending in Massachusetts: An Analysis of Options 99, 102–03 (Aug. 2009) (discussing relative cost of care for simple acute conditions of cough, throat symptoms, fever, earache, skin rash, and nasal congestion).
12. Technical Appendix, Part III.2 (applying findings of *Eibner*, *supra* note 11 and Christopher J. Conniver et al., Economic Benefits of Less Restrictive Regulation of Advanced Practice Registered Nurses in North Carolina (Feb. 2015)).