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NOTES

RETAIL THERAPY: HOW A TRIP TO THE STORE CAN MAKE YOU
FEEL BETTER IN THE EVOLVING HEALTH CARE LANDSCAPE
CREATED BY THE AFFORDABLE CARE ACT

Cynthia Liba



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NOTES

RETAIL THERAPY: HOW A TRIP TO THE STORE CAN MAKE YOU FEEL BETTER IN THE EVOLVING HEALTH CARE LANDSCAPE CREATED BY THE AFFORDABLE CARE ACT

*Cynthia Liba**

I. INTRODUCTION

Quality, cost, and access are the three fundamental areas of contention that society struggles to balance in the health care arena.¹ The Obama Administration, through the Patient Protection and Affordable Care Act (ACA), is attempting to rebuild and reform the inefficient and problematic health care system in the United States. In the United States, almost 20% of the gross domestic product is spent on health care.² Other developed countries spend half as much on health care, and yet, the health care provided in America is no better, and often worse, by comparison.³ As the ACA expands Medicaid eligibility by creating a national Medicaid minimum eligibility level of 133% of the federal poverty level⁴ and requires U.S. citizens to purchase health insurance as a result of the individual mandate, the shortage of primary care physicians will become painfully

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¹ FED. TRADE COMM'N, IMPROVING HEALTH CARE: A DOSE OF COMPETITION: A REPORT BY THE FEDERAL TRADE COMMISSION AND THE DEPARTMENT OF JUSTICE (July 2004), available at http://www.ftc.gov/sites/default/files/documents/reports/improving-health-care-dose-competition-report-federal-trade-commission-and-department-justice/040723health_care rpt.pdf.

² Steven Brill, *Bitter Pill: Why Medical Bills Are Killing Us*, TIME, Feb. 20, 2013.

³ *Id.*

⁴ *Eligibility*, MEDICAID.GOV, <http://www.medicaid.gov/Medicaid-CHIP-Program-Information/By-Topics/Eligibility/Eligibility.html> (last visited Mar. 18, 2014).

apparent for those seeking treatment.⁵ As a result, many health policy analysts and lawmakers are examining the potential ability of retail health clinics (RHCs) to address the consequences of primary care physician shortages in the United States, among other deficiencies in the provision of health care.⁶

A. *What Is an RHC?*

Rick Krieger created the first RHC. The idea was sparked during an after-hours visit to an urgent care center with his son who had a sore throat.⁷ Krieger had limited choices as to where to bring his son and was forced to wait over two hours for treatment and diagnosis.⁸ Krieger acknowledged that the health care industry “. . . was designed to solve *any* problem . . . as skilled physicians were required to handle any complicated cases that *might* walk through the door.”⁹ Krieger wanted to follow in the footsteps of a company that was able to conveniently bring quality services with lesser-trained employees, at low prices, to billions of people.¹⁰ Krieger set out to establish the “McDonald’s of health care.”¹¹ Krieger went on to establish the MinuteClinic at CVS. Today, CVS’s website contains a page detailing the company’s history and achievements through the years. Under “2013” the following sentence appears: “MinuteClinic reaches the new milestone of 18 million patient visits and 800 clinics in 27 states by year end, well on the way to the goal of 1,500 clinics in 35 states by 2017.”¹²

⁵ Jen Christensen, *Doctor Shortage, Increased Demand Could Crash Health Care System*, CNN (Oct. 2, 2013), <http://www.cnn.com/2013/10/02/health/obamacare-doctor-shortage/>.

⁶ Lisa Zamosky, *What retail clinic growth can teach physicians about patient demand*, MEDICAL ECONOMICS (Jan. 8, 2014), <http://medicaleconomics.modernmedicine.com/medical-economics/news/what-retail-clinic-growth-can-teach-physicians-about-patient-demand>.

⁷ Donna L. Haugland & Patricia J. Hughes, *Retail Health Care Clinics: Filling a Gap in the Health Care System*, http://www.elsevieradvantage.com/samplechapters/9780323242417/Mason%206e%20RR_Ch%2031_0041-ch0031-0252-0259-9780323242417.pdf (last visited Mar. 13, 2015).

⁸ *Id.*

⁹ SCOTT D. ANTHONY, *THE LITTLE BLACK BOOK OF INNOVATION: HOW IT WORKS, HOW TO DO IT* 129 (2011).

¹⁰ *Id.*

¹¹ *Id.*

¹² *Company History*, CVS CAREMARK (2014), <http://info.cvscaremark.com/about-us/our-purpose/company-history>.

Clearly, RHCs are proving to be a successful and in demand fixture in the health care sphere.

RHCs are walk-in clinics predominantly run by retailers that contain pharmacies such as CVS, Walgreens, Wal-Mart and Target, as well as some grocers like Kroger.¹³ RHCs are generally staffed by non-physician medical professionals such as nurse practitioners (NPs), advanced nurse practitioners (ANPs), and physician assistants (PAs). They provide preventative care, treat minor and simple acute conditions (such as strep throat and pink eye), and administer vaccinations.¹⁴ Typically, RHCs are “open seven days a week, with extended weekday hours; no appointments are necessary and visits generally take 15 to 20 minutes due to the limited scope of services offered.”¹⁵

There are many legal barriers to the creation of RHCs across the United States. Laws governing the corporate practice of medicine, scope of practice, physician supervision, certificate of need, and liability under federal Stark II and anti-kickback laws may play a part in restricting the success of RHCs.¹⁶ This note will address licensure, scope of practice, and physician supervision laws in relation to RHCs in the United States. Health care is a highly regulated area.¹⁷ It is logical that a complex regulatory scheme exists in health care, as oversight is needed when the health of society is at stake.¹⁸ Although a degree of regulation is necessary, I will argue that in many instances, laws need to be relaxed for the population to gain better access to care.

¹³ Bruce Jaspens, *CVS Drives Retail Clinic Growth As Obamacare Launches*, FORBES (Dec. 5, 2013), <http://www.forbes.com/sites/brucejaspens/2013/12/05/cvs-drives-retail-clinic-growth-as-obamacare-launches/>.

¹⁴ *Retail Health Clinics: State Legislation and Laws*, NAT'L CONF. OF STATE LEGS., <http://www.ncsl.org/research/health/retail-health-clinics-state-legislation-and-laws.aspx> (last updated Nov. 2011; material added Nov. 2014).

¹⁵ *Id.*

¹⁶ See Kaj Rozga, Note and Comment, *Retail Health Clinics: How the Next Innovation in Market-Driven Health Care Is Testing State and Federal Law*, 35 AM. J.L. & MED. 205 (2009) (for a more in-depth description of these principles and their applicability to RHCs).

¹⁷ Robert I. Field, *Why Is Health Care Regulation So Complex?*, 33 PHARMACY & THERAPEUTICS 607 (Oct. 2008), available at <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2730786/>.

¹⁸ *Id.*

II. A CALL FOR CHANGE IN STATE SCOPE OF PRACTICE LAWS

As a result of health care conditions created by the ACA, it is necessary to allow for increased flexibility in state regulation of scope of practice licensing laws to permit the advancement and utility of RHCs. Legal authority to alter scope of practice laws lie with state-based health professional licensing laws.¹⁹ Varying state laws that govern the scope of practice of NPs, ANPs, and PAs must be revised to limit the required level of physician supervision so that nurse practitioners have more autonomy to diagnose and prescribe medication. The predicted benefits of expanding the scope of practice laws are great as the number of primary care providers would increase and physicians would be free to care for more patients with more complex ailments.²⁰ Nurses are an extremely versatile resource in the health care workforce.²¹ The U.S. health care system suffers when such a resource is not utilized, as “[a]rtificial scope of practice restrictions prevents health care professionals from performing the full range of skills for which they have been trained, limit consumer access to care and choice of providers, and inflate the cost of health care.”²²

Medical students that graduate with thousands of dollars in debt choose to become specialists, which is a more lucrative career path, as opposed to the low-paying primary care physician.²³ A study in the *Annals of Family Medicine* concluded that the United States will require nearly 52,000 additional primary care physicians by 2025 due to population growth, the aging population, and insurance expansion.²⁴ Non-physician medical professionals should be allowed to fill the void in primary health care so that the promise of increased access to health care can come to

¹⁹ Rebecca LeBuhn & David A. Swankin, *Reforming Scopes of Practice: A White Paper* (2010), <https://www.ncsbn.org/ReformingScopesofPractice-WhitePaper.pdf>.

²⁰ Tracy Yee et al., *Primary Care Workforce Shortages: Nurse Practitioner Scope-of-Practice Laws and Payment Policies*, NAT'L INST. FOR HEALTH CARE REFORM (Feb. 2013), <http://www.nihcr.org/index.php?download=1tclfl229>.

²¹ COMM. ON THE ROBERT WOOD JOHNSON FOUND. INITIATIVE ON THE FUTURE OF NURSING, INSTITUTE OF MEDICINE, *THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH* 87 (2011).

²² LeBuhn & Swankin, *supra* note 19, at 3.

²³ Christensen, *supra* note 5.

²⁴ Stephen M. Petterson et al., *Projecting US Primary Care Physician Workforce Needs: 2010–2015*, 10 ANN. FAM. MED. 503, 507 (2012).

fruition. Society must adapt to changing circumstances and needs in order to avoid becoming stagnant and unproductive.

Though a need for physician involvement and supervision in retail clinics remains, that role should not be as involved as many states scope of practice laws require. Physicians have experienced a thorough training process and there are procedures only they should be permitted to provide.²⁵ However, all members of the health care workforce should be able to “practice to the full extent of their education and training so that more patients may benefit.”²⁶

The creation of non-physician medical specialties such as NPs developed in a health care climate similar to the conditions that exist today. PAs and NPs were established during a time of increased demand for medical services resulting from the post-war baby boom and the subsidization of medical care.²⁷ As demands for health care services change and grow, so too must the laws that regulate and govern the system in order for innovation to flourish. A physician who works in an emergency room in Lexington, Kentucky stated, “I think of (Obamacare) as giving everyone an ATM card in a town where there are no ATM machines. The coming storm of patients means when they can’t get in to see a primary care physician, even more people will end up with me in the emergency room.”²⁸ As an increased health care force was needed in post-World War II America, an increased health care force is needed in post-Obamacare America. Retail clinics hold the power to increase access to health care at lower costs without compromising quality. State law must catch up with realities of health care demands created by the ACA for any significant evolution of health care to occur.

In his testimony before the House Committee on Energy and Commerce Subcommittee on Health, the President of the American Association of Neurological Surgeons promoted the increased utilization of NPs and PAs. He stated, “NPs and PAs are trained more quickly, at less expense than physicians, cost less in practice . . . provide a well-proven

²⁵ INSTITUTE OF MEDICINE, *supra* note 21, at 96.

²⁶ *Id.*

²⁷ Aaron Hoffmann, *Minute Medicine: Examining Retail Clinic Legal Issues and Legislative Challenges*, 20 HEALTH MATRIX 467, 473 (2010).

²⁸ Christensen, *supra* note 5.

quality, clinical workforce that can interdigitate with all aspects of physician practice and whose pipeline can be turned up or down as needed to assist in addressing emerging or changing clinical needs.”²⁹ Scope of practice regulations are often rationalized on the assumption that the laws protect patients.³⁰ However, research demonstrates that the quality of primary care provided by NPs is similar to that provided by physicians.³¹

State licensing boards that determine scope of practice laws have been found to be self-serving. The boards are made up of physicians that may be motivated to serve their own economic self-interests rather than public interests.³² Physicians may be threatened due to an overlap of duties that non-physician medical professions are trained to perform.³³ Members of licensing boards, therefore, may prefer to prevent the expansion of scope of practice laws to protect their personal interests. There must be a greater push to place a diverse group of professionals on state medical boards, such as nurses and lawyers, to control the problems that are associated with professional self-regulation. The unnecessary level of restriction created by economically motivated state licensing laws must be relaxed so competent medical professionals can provide care to the thousands of people about to gain access to health care as a result of the ACA.

The court in *The State Board of Nursing and State of Kansas ex rel. State Board of Healing Arts v. Ruebke* expressed concerns the state board was motivated by economic protectionism.³⁴ The State Board of Healing Arts and the State Board of Nursing sought to prevent lay midwives from practicing medicine and nursing.³⁵ The court noted that:

Economically and socially well-placed doctors pressed for more restrictive licensing laws and for penalties against those who violated them. . . . licensure was a market control device; midwives were depriving new obstetricians of the

²⁹ LeBuhn & Swankin, *supra* note 19.

³⁰ Joanne Spetz et al., *Scope-Of-Practice Laws For Nurse Practitioners Limit Cost Savings That Can Be Achieved In Retail Clinics*, 32 HEALTH AFF. 1977, 1982 (2013).

³¹ *Id.*

³² Deborah Haas-Wilson, *The Regulation of Health Care Professionals Other than Physicians*, REGULATION (Fall 1992), available at <http://www.cato.org/sites/cato.org/files/serials/files/regulation/1992/10/reg15n4d.html>.

³³ INSTITUTE OF MEDICINE, *supra* note 21, at 97.

³⁴ State Bd. of Nursing v. Ruebke, 913 P.2d 142, 149 (Kan. 1996).

³⁵ *Id.* at 142.

opportunity for training, and elimination of midwifery would allow the science of obstetrics to grow into a mature medical specialty.³⁶

The court ultimately decided that the terms of the state medical statute focuses exclusively on pathologies and abnormalities to define the practice of medicine.³⁷ As pregnancy and childbirth are neither pathologies nor abnormalities, the conduct of the midwives was held to not constitute the practice of medicine. Thus, midwives were permitted to continue to practice their duties.³⁸

In *Sermchief v. Gonzales*, a case from the Supreme Court of Missouri, also illustrates the arguments made by a state licensing board challenging the scope of practice of professional nurses. Members of the Missouri State Board of Registration for the Healing Arts (the Board) charged two licensed professional nurses with the unauthorized practice of medicine.³⁹ The procedures at issue, such as taking of history, breast and pelvic examinations, and blood serology, were all acts done pursuant to orders signed by physicians.⁴⁰ The Board also charged the physicians who signed the orders with aiding and abetting the unauthorized practice of medicine. At issue was whether the conduct of the nurses constituted “Professional Nurses” as defined in the Nursing Practice Act of 1975. The court stated that there was “a manifest legislative desire to expand the scope of authorized nursing practice evidenced by the elimination of the requirement that a physician directly supervise nursing functions” and the legislature’s “formulation of an open-ended definition of professional nursing.”⁴¹ The court reasoned that the procedures the nurses undertook fell within the legislative standards.⁴²

As the *Sermchief* court and other courts across the United States decline to draw a definitive line separating the practice of medicine and the practice of professional nursing, physicians and state medical boards that

³⁶ *Id.* at 149.

³⁷ *Id.* at 155.

³⁸ *Id.*

³⁹ *Sermchief v. Gonzales*, 660 S.W.2d 683, 684 (Mo. 1983).

⁴⁰ *Id.* at 684–85.

⁴¹ *Id.* at 689.

⁴² *Id.*

would prefer to maintain a monopoly over medical conduct will likely continue to create legal challenges to advanced nursing practices.⁴³

A. Pennsylvania: A Case Study

In 2007, the then Governor of Pennsylvania, Ed Rendell, announced a new bill for health care reform that included expanding the scope of practice of the non-physician health care workforce.⁴⁴ The bill, known as the “Prescription for Pennsylvania,” set out to “relieve shortages of primary care providers; ensure access to cost-effective health care for citizens of all racial, ethnic, and language backgrounds; improve access to health care services in evenings and weekends; and, increase the diversity of the health care workforce.”⁴⁵ The legislation expanded and clarified with specificity the roles of Physician Assistants, Respiratory Care Practitioners, Advanced Registered Nurse Practitioners, Physical Therapists, and Public Health Dental Hygiene Practitioners.⁴⁶ For example, the bill lists a number of procedures a Physician’s Assistant is legally allowed to conduct “provided that the physician assistant is acting within the supervision and direction of the supervising physician.”⁴⁷

Demographic information specific to Pennsylvania demonstrates how expanding the scope of practice laws will benefit the residents of Pennsylvania. The information reflects that, “Pennsylvania’s 3,195 Nurse Anesthetists, 6,637 Advanced Practice Registered Nurses, and more than 5,000 Physician Assistants will have an expanded scope of practice, resulting in patients getting more personalized attention and freeing physicians to concentrate on more challenging therapies.”⁴⁸ In addition, “community and retail clinics staffed by Advanced Practice Registered Nurses are likely to become more abundant, with particular impact in rural areas where nearly three and a half million Pennsylvanians reside.”⁴⁹

⁴³ Linda H. Aiken & William M. Sage, *Staffing National Health Care Reform: A Role for Advanced Practice Nurses*, 26 AKRON L. REV. 187, 200 (1992).

⁴⁴ INSTITUTE OF MEDICINE, *supra* note 21, at 112.

⁴⁵ LeBuhn & Swankin, *supra* note 19.

⁴⁶ H.R. 1804 Gen. Assemb., Reg. Sess. (Pa. 2008).

⁴⁷ *Id.*

⁴⁸ LeBuhn & Swankin, *supra* note 19.

⁴⁹ *Id.*

Further, the expansion and increased flexibility of scope of practice legislation holds the potential to aid rural populations across the United States.⁵⁰ Twenty-five percent of the U.S. population lives in rural areas, and yet, only ten percent of physicians practice in such areas.⁵¹ The people that reside in rural areas, who are generally poor and in poor health, need a consistent source of primary care that non-physician medical professionals are qualified to provide. It is not the education or capabilities that are holding back ANPs from providing such services; it is restrictive laws that have not evolved with the changing demands of health care.⁵²

Governor Rendell was able to successfully amend restrictive and outdated laws that inhibited the people of Pennsylvania from accessing quality low-cost health care. Pennsylvania now provides a model that should be followed by many other states, especially in light of the increased pressure on the health care market resulting from the ACA. In fact, the New Jersey State Nurses Association has pointed to the positive impact of Governor Rendell's actions when discussing the necessity of removing barriers to APNs in their own state.⁵³ If more state legislators amended scope of practice laws to reflect the realities of health care needs, perhaps the U.S. health care system would experience less turmoil and more success.

B. Variation in Scope of Practice Laws Throughout the United States

One reason for the success of the expansion of scope of practice laws in Pennsylvania was that that the opposition was satisfied with the "decision to link scope expansions to collaborative practice agreements calling for some level of supervision or delegation by one profession over another."⁵⁴ The degree of physician oversight thought to be necessary wildly varies among the states. As of February 2013, "18 states plus the

⁵⁰ INSTITUTE OF MEDICINE, *supra* note 21, at 107.

⁵¹ *Id.*

⁵² *Id.* at 95.

⁵³ NEW JERSEY STATE NURSES ASSOCIATION, *Maximizing Access to Health Care In New Jersey: The Case for Advanced Practice Nurses: A White Paper*, <http://c.ymcdn.com/sites/www.njsna.org/resource/resmgr/imported/WHITE%20PAPER%20ON%20MAXIMIZING%20ACCESS%20TO%20HEALTH%20CARE%20IN%20NJ.pdf> (last visited Jan. 15, 2014).

⁵⁴ LeBuhn & Swankin, *supra* note 19.

District of Columbia permit NPs to diagnose and treat patients and prescribe medications without physician oversight, while seven states require physician oversight of NP prescribing only, and 25 states require oversight of NPs' diagnoses, treatment plans and prescribing."⁵⁵

Massachusetts regulated retail clinics through executive action.⁵⁶ On January 3, 2014, the state of Massachusetts amended its laws regarding the requirements for clinic licensure.⁵⁷ Under the law,

One or more physicians, as necessary, shall provide or supervise the provision by the clinic of all services involving the practice of medicine. At least one physician shall be present at the clinic whenever medical services are provided, unless these services are provided pursuant to written protocols or guidelines by a physician assistant or a nurse practicing in an expanded role in accordance with the regulations of the appropriate registration board.⁵⁸

Arizona, on the other hand, does not require that a licensed physician be on-site during working hours of an urgent care clinic. Arizona law provides that when a licensed physician is not on site, "as a condition of licensure, the center must post a conspicuous sign stating this fact. The center must post this sign in the center's patient waiting room in full view of the patients."⁵⁹ In Florida, "[a] physician who is engaged in providing primary health care services may not supervise more than four offices in addition to the physician's primary practice location."⁶⁰

Clearly, states disagree on the level of physician oversight required. Some states have enacted legislation specific to retail clinics such as Massachusetts, and others have not. However, a degree of physician supervision is necessary at retail clinics as non-physician practitioners may not be capable of handling every condition they encounter. It should not be construed as weakness that non-physician practitioners may need to refer a patient to a physician, since "APRNs have competencies that include the knowledge to refer patients with complex problems to physicians, just as physicians refer patients who need services they are not trained to provide, such as medication counseling, developmental screening, or case

⁵⁵ Yee et al., *supra* note 20.

⁵⁶ NAT'L CONF. OF STATE LEGS., *supra* note 14.

⁵⁷ 2014 MA REG. TEXT 330864 (NS).

⁵⁸ *Id.*

⁵⁹ ARIZ. REV. STAT. ANN. § 36-432.

⁶⁰ FLA. STAT. ANN. § 459.025 (2012).

management, to APRNs.”⁶¹ Though supervision is necessary, laws regulating the degree of supervision should be relaxed to provide non-physician practitioners with an amount of autonomy correlative to their knowledge and training.⁶² Rather, the use telecommunication and telemedicine as a source of physician oversight of RHCs should be utilized, as further discussed in the next section.

III. TELECOMMUNICATION AND TELEMEDICINE

A. Increasing the Ease of Physician Oversight at RHCs

State laws should be further amended to more easily permit the use of telecommunications, so that physicians can supervise the non-physician workforce without having to be on-site at RHCs during working hours. Telemedicine has been defined as “the use of electronic communication and information technologies to provide or support clinical care at a distance.”⁶³ Telemedicine “may be as simple as two health professionals discussing a case over the telephone, or as complex as using satellite technology and video-conferencing equipment to conduct a real-time consultation between medical specialists in two different countries.”⁶⁴ State laws require that a physician that practices medicine in a state be licensed in that state, which presents a barrier to the wide use of telemedicine.⁶⁵ Although the restrictions on inter-state medical advice should be relaxed, there are smaller steps that can be taken initially. As the practice of telemedicine across state lines remains a point of contention, intrastate telecommunication should be permitted so that retail clinics can use various forms of technology as a mode of physician supervision.

⁶¹ INSTITUTE OF MEDICINE *supra* note 21, at 97.

⁶² Devon Herrick, *Retail Clinics: Convenient and Affordable Care*, NATIONAL CENTER FOR POLICY ANALYSIS (Jan. 14, 2010), <http://www.ncpa.org/pub/ba686>.

⁶³ See NAT'L TELECOMM. & INFO. ASS'N, *TELEMEDICINE REPORT TO CONGRESS* (1997), available at <http://www.ntia.doc.gov/legacy/reports/telemed/execsum.htm>.

⁶⁴ *What is Telemedicine?*, NEWS MEDICAL, <http://www.news-medical.net/health/What-is-Telemedicine.aspx> (last updated Aug. 6, 2013).

⁶⁵ Talley L. Kaleko, *A Bold Step: What Florida Should Do Concerning the Health of Its Rural Communities, Licensure, and Telemedicine*, 27 FLA. ST. U. L. REV. 767, 769 (2000).

In the current tumultuous state of health care in the United States, legislatures must take action to optimize resources to their fullest potential. The full capabilities of both non-physician health care workers and technological advancements must be exhausted. Although, state legislatures should enact legislation that allows RHCs to be supervised with intrastate telecommunication in light of the demands of the ACA, permanently restricting telemedicine to intrastate commerce will likely prevent the health care industry from obtaining full economic advantage of the practice.⁶⁶ Eventually, it is hoped that state laws will permit the expansion of telemedicine across state lines.

A prime example of a state legislature permitting the use of telecommunications specifically for supervision for RHCs is the state of Illinois. Legislation enacted in 2014 states that a written collaborative agreement between a physician and APN is adequate if, among other things, “methods of communication are available with the collaborating physician in person or through telecommunications for consultation, collaboration, and referral as needed to address patient care needs.”⁶⁷ As RHCs typically only address simple acute health conditions, such as a respiratory or urinary tract infection,⁶⁸ it seems to be an unnecessary expenditure of resources to demand a physician to always be on site when services are provided, as is required in Massachusetts. I believe that more states should follow the footsteps of Illinois so that access to quality care at a low cost can be ascertainable.

Off-site physicians who are available through telemedicine communications, such as a telephone call or videoconference, should be considered to be supervising RHCs. However, there should be a system in place to constrain the types of conditions that can be treated at the clinic. With regard to supervision, non-physician practitioners should initiate the supervision or assistance. As previously stated, non-physician practitioners possesses the expertise to know when to refer patients with complex

⁶⁶ *Id.* at 772.

⁶⁷ 225 ILL. COMP. STAT. 60/54.5(b)(5) (2014).

⁶⁸ Stephanie Watson, *More Americans using retail health clinics*, HARVARD HEALTH BLOG (May 10, 2013), <http://www.health.harvard.edu/blog/more-americans-using-retail-health-clinics-201305106189>.

problems to physicians.⁶⁹ When a supervising physician contacted through telemedicine is too far away to provide necessary care that non-physicians also cannot provide, “clinics will have referral relationships in place with local physicians or hospitals for customers with conditions that fall outside of their treatment scope and who need a regular source of care.”⁷⁰ There should also be a sign that informs patients that a physician is not on site, as required under Arizona law.

If the procedures RHCs perform are limited to treating simple acute conditions and providing preventive care and non-physician practitioners are working within the scope of their educational expertise, telemedicine will prove to be a more than sufficient mode of supervision for non-physician practitioners in RHCs.

B. Use of Telemedicine in the Direct Provision of Care at RHCs

RHCs are not only dabbling with the use of telemedicine as a form of physician supervision, but also as a mechanism to provide care. Early in 2013, Rite Aid became the first retail provider to use telemedicine when it announced plans for its use in 58 of its Now Clinic Program.⁷¹ The use of telemedicine “allows health clinic patients to have a private, one-on-one consultation via video conference with a physician” as opposed to a nurse-practitioner.⁷² Other retailers are predicted to make use of telemedicine in the near future to remain competitive in the market.⁷³ According to The American Telemedicine Association, “there are currently 200 telemedicine networks operating in the United States using more than 3,500 sites. The association estimates that 50% of U.S. hospital networks now use some form of telemedicine.”⁷⁴ However, legal barriers to licensure still remain an issue.

⁶⁹ INSTITUTE OF MEDICINE, *supra* note 21, at 97.

⁷⁰ *Health Care in the Express Lane: Retail Clinics Go Mainstream*, CALIFORNIA HEALTH CARE FOUNDATION (Sept. 2007), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareInTheExpressLaneRetailClinics2007.pdf>.

⁷¹ Doug Desjardins, *Telemedicine is RHCs' Newest Tool*, HEALTHLEADERS MEDIA (May 8, 2013), <http://www.healthleadersmedia.com/page-1/TEC-291947/Telemedicine-is-Retail-Health-Clinics-Newest-Tool>.

⁷² *Id.*

⁷³ *Id.*

⁷⁴ *Id.*

On November 26, 2013, representatives of state medical boards announced their progress with a plan for medical licensing that would facilitate a process for physicians who wish to attain a license providing them the ability to practice in multiple states. The proposed system is known as the Interstate Medical Licensure Compact:

Under the new system, physicians interested in practicing in multiple states would be able to receive a license in each state and be under the jurisdiction of the state medical board where the patient is located at the time of the medical interaction. Participating state medical boards would retain their licensing and disciplinary authority but would agree to share information and processes essential to the licensing and regulation of physicians who practice across state borders. Participation in an interstate compact would be voluntary, for both states and physicians. The new interstate compact system is expected to significantly reduce barriers to the process of gaining licensure in multiple states, helping facilitate licensure portability and telemedicine while widening access to health care by physicians, particularly in underserved areas of the nation.⁷⁵

The Interstate Medical Licensure Compact is an innovative and realistic way to expedite the progress of medical care in the United States. Many argue that medical licensure should remain state based, as opposed to a national federalized medical licensure movement, to protect patients.⁷⁶ This compact may provide a feasible solution that will satisfy the goals of various interest groups. For example, the American Medical Association (AMA) “urges licensing jurisdictions to pass laws and adopt regulations facilitating the movement of licensed physicians between licensing jurisdictions.”⁷⁷ The Interstate Medical Licensure Compact holds great potential to revolutionize health care in the United States.

⁷⁵ *State Medical Board Leaders Make Progress Towards an Interstate Compact for Physician Licensure*, NEWSWISE (Nov. 26, 2013), <http://www.newswise.com/articles/state-medical-board-leaders-make-progress-towards-an-interstate-compact-for-physician-licensure>.

⁷⁶ Drew Carlson, *Federation of State Medical Boards to Explore Use of Interstate Compact for Physician Licensure*, FSMB (Apr. 23, 2013), http://library.fsmb.org/pdf/fsmb_news_release_multistate_compacts.pdf.

⁷⁷ *H-275.978 Medical Licensure*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=/resources/html/PolicyFinder/policyfiles/HnE/H-275.978.HTM> (last visited Mar. 13, 2015).

IV. OPPOSITION TO SCOPE OF PRACTICE LAW EXPANSION AND RETAIL CLINICS

Despite the obvious need for RHCs in today's health care environment, various groups have expressed their concerns and criticisms of RHCs. These groups include the American Academy of Pediatrics (AAP), the AMA, and the American Academy of Family Practice (AAFP). The AAFP is concerned with fragmentation of care, the possible effects on quality care, and the provision of episodic care to children with special needs and chronic conditions.⁷⁸ Though the AAP lists a variety of concerns, they acknowledge that the current economic conditions supports the proliferation of RHCs.⁷⁹ As a result, the AAP provides recommendations for RHCs which include: communications with the patients pediatrician or primary care physician within 24 hours of the visit, assisting families to establish a contact with a medical home that will provide continues and coordinated care, and eliminating financial incentives for visits to RHCs in lieu of primary care physician offices.⁸⁰ The AAFP also stresses the importance of establishing a medical home.⁸¹ The AAFP expresses concerns about fragmentation of patient care and the need for services that are provided at RHCs to be coordinated with a patient's primary care physician.⁸²

A takeaway from these critiques is, although various organizations have concerns, these organizations recognize the need and demand for RHCs in America. These organizations may not explicitly advocate for RHCs, but they provide guidelines for RHCs as they recognize that the current economic dynamics will support the existence of RHCs.⁸³ We are beyond wondering whether RHCs should exist; the question remains, how

⁷⁸ *AAP Principles Concerning Retail-Based Clinics*, AMERICAN ACADEMY OF PEDIATRICS (Dec. 1, 2006), http://pediatrics.aappublications.org/content/118/6/2561.full?ijkey=5bba05f62f27e82933767b0793354ebd5595c9d9&keytype=tf_ipsecsha.

⁷⁹ *Id.*

⁸⁰ *Id.*

⁸¹ *Retail Clinics*, THE AMERICAN ACADEMY OF FAMILY PHYSICIANS, <http://www.aafp.org/about/policies/all/retail-clinics.html> (last visited Mar. 13, 2015).

⁸² *Id.*

⁸³ AMERICAN ACADEMY OF PEDIATRICS, *supra* note 78.

will regulation balance opposing concerns regarding this novel and necessary health care innovation?

Many groups oppose expanding scope of practice legislation, “arguing that nurses lack the training to safely diagnose, treat, refer to specialists, admit to hospitals and prescribe medications for patients, without a doctor’s oversight.”⁸⁴ For example, the AMA has persistently opposed state legislation aimed at expanding the scope of practice for medical professionals other than physicians.⁸⁵ AMA Resolution H-35.988 states it is in the public interest to “oppose enactment of legislation that authorizes the independent practice of medicine by any individual who has not completed the states requirements for licensure to engage in the practice of medicine. . . .”⁸⁶ AMA Resolution H-160.947 states the AMA will “develop a plan to lobby against laws that allow advanced practice nurses to provide medical care without the supervision of a physician.”⁸⁷ Resolution H-160.947 also states “the physician must be available for consultation with the physician assistant at all times, either in person or through telecommunication systems or other means.”⁸⁸

A main concern for the AMA appears to be the provision of care by non-physician professionals without the supervision of a professional. The care given by non-physician professionals at RHCs must be supervised; however, that supervision should be limited to optimize access and lower costs. As the AMA does not require in-person physician consultation and permits physician assistance through telecommunication, the AMA leaves the door open for the limited physician supervision that would allow RHCs to thrive. Washington is also taking notice of the importance of telemedicine.

⁸⁴ Christine Vestal, *Nurse Practitioners Slowly Gain Autonomy*, KAISER HEALTH NEWS (July 19, 2013), <http://www.kaiserhealthnews.org/stories/2013/july/19/stateline-nurse-practitioners-scope-of-practice.aspx>.

⁸⁵ *Health Care in the Express Lane: Retail Clinics Go Mainstream*, CALIFORNIA HEALTH CARE FOUNDATION (Sept. 2007), <http://www.chcf.org/~media/MEDIA%20LIBRARY%20Files/PDF/H/PDF%20HealthCareInTheExpressLaneRetailClinics2007.pdf>.

⁸⁶ *H-160.947 Physician Assistants and Nurse Practitioners*, AMERICAN MEDICAL ASSOCIATION, <https://www.ama-assn.org/ssl3/ecomm/PolicyFinderForm.pl?site=www.ama-assn.org&uri=%2fresources%2fhtml%2fPolicyFinder%2fpolicyfiles%2fHnE%2fH-160.947.HTM> (last visited Mar. 13, 2015).

⁸⁷ *Id.*

⁸⁸ *Id.*

V. ECONOMIC RAMIFICATIONS

RHCs constitute consumer-controlled health care that will increase competition. In *North Pacific Railroad Co. v. United States*, the Supreme Court stated that “unrestrained interaction of competitive forces will yield the best allocation of our economic resources, the lowest prices, the highest quality and the greatest material progress. . . .”⁸⁹ Health care is currently an area where the flow of information is stunted and the level of competition is negligible.⁹⁰ However, the ACA is attempting to increase competition in the insurance market by increasing choice by drawing additional insurance companies into states controlled by few carriers and allowing consumers to shop for insurance on an exchange.⁹¹ Similarly, if patients are given access to more primary care providers they will be able to shop for the best value, thus increasing competition. Retail clinics hold the potential for increased information, choice, and competitiveness, ultimately leading to better quality care for more individuals.

With the busy and demanding schedules of many people in the United States, “almost two thirds of Americans have trouble getting care on nights, weekends, and holidays.”⁹² As retail clinics offer expanded hours, primary care physicians will be pressured to expand their hours of operation and offer walk-in services as well, increasing competition and access to care for more people in the United States.⁹³ In addition, an expert panel organized by the RAND Corporation found that “the importance of customer service more generally was highlighted as being of high importance to patients and as something not commonly found in physician offices.”⁹⁴ In addition, “the fact that a retail clinic’s services cost less is an additional incentive for consumers that will also be embraced by their insurers, helping to drive

⁸⁹ *North Pacific Railroad Co. v. United States*, 356 U.S. 1, 4 (1958).

⁹⁰ Brill, *supra* note 2.

⁹¹ Robert Pear, *Health Law Is Fostering Competition*, U.S. SAYS, N.Y. TIMES (May 30, 2013), http://www.nytimes.com/2013/05/31/health/health-law-is-fostering-competition-administration-says.html?_r=0.

⁹² Aaron Carroll, *If You Don’t Like Retail Clinics, Do What They Do Better*, THE INCIDENTAL ECONOMIST (Dec. 6, 2011), <http://theincidentaleconomist.com/wordpress/if-you-dont-like-retail-clinics-do-what-they-do-better/>.

⁹³ Robin M. Weinick et al., *Policy Implications of the Use of Retail Clinics*, RAND CORPORATION (2010), http://www.rand.org/content/dam/rand/pubs/technical_reports/2010/RAND_TR810.pdf.

⁹⁴ *Id.*

further utilization.”⁹⁵ Insurers are quickly discovering that the use of retail clinics can create savings not only through steerage from emergency rooms but also from shifting treatment of minor medical conditions away from physician offices and urgent care clinics.

As noted earlier, a number of insurers have decided to waive co-payments in an attempt to shift demand to retail clinics. This is likely based on their cost experience. A study by HealthPartners, an insurer operating primarily in Minnesota, found that a visit to a retail clinic was, on average, \$18 cheaper than a visit to a traditional primary care setting.⁹⁶ The convenience, personal attention, and lower costs of emerging retail clinic will likely spur competition.

RHCs are able to solve another grave problem in the U.S. health care system: a lack of price transparency. For example, the covert methodology hospitals invoke to charge their patients has caused financial heartache for many U.S. citizens. A hospital’s internal price list is called a chargemaster. Steve Brillo, the author of *Bitter Pill: Why Medical Bills Are Killing Us*, stated that the chargemaster is treated as an “eccentric uncle living in the attic.”⁹⁷ When Brillo asked hospital officials about the chargemaster all questions were deflected away from it and the document was treated as if it were irrelevant.⁹⁸ Brillo stated that “. . . there seems to be no process, no rationale, behind the core document that is the basis for hundreds of billions of dollars in health care bills.”⁹⁹

Access to information is an intrinsic characteristic of a properly working market as information permits consumers to shop for the best product and will force providers to scrutinize their practices in relation to their competitive rivals.¹⁰⁰ The lack of information transparency in the prices of medical care impedes competition, and potentially, the use of the medical system in general. Based upon Richard Krieger’s McDonald’s model, many RHCs provide “price menus” which list the prices of

⁹⁵ Paul H. Keckley, *Retail Clinics Facts, Trends and Implications*, DELOITTE CENTER FOR HEALTH SOLUTIONS (2008), <http://www.amcp.org/WorkArea/DownloadAsset.aspx?id=11959>.

⁹⁶ *Id.*

⁹⁷ Brill, *supra* note 2.

⁹⁸ *Id.*

⁹⁹ *Id.*

¹⁰⁰ Michael E. Porter & Elizabeth Teisberg, *Redefining Competition in Health Care*, HARVARD BUSINESS REVIEW (2004), <https://hbr.org/2004/06/redefining-competition-in-health-care>.

vaccines, physicals and wellness visits, health screenings, diagnostic tests, and other services the RHC provides.¹⁰¹

Another financial benefit of retail health clinics is that a visit to a retail clinic is likely not to disrupt a person's daily routine or inconvenience them to an extent where they have to miss work. One study found, "employers in the United States spend \$226 billion a year on productivity losses due to employee and family related health issues."¹⁰² Perhaps, RHCs will be able to decrease the amount of money spent due to loss of productivity by making access to acute health care more convenient and accessible. With increased convenience in the provision of preventive health care provided by RHCs, America will be able to save money and lives.

Many other economic benefits of RHCs have been asserted:

Low overhead costs from their small spaces, lack of expensive equipment, minimal or no support staff, and lower salaries for non-physician providers allow retail clinics to offer lower costs for the services that they offer—approximately 30% to 40% less than in a physician's office and 80% less than in an emergency department.¹⁰³

Another study performed by the RAND Corporation found that the average cost of care for three prevalent conditions amounted to "\$110 at retail clinics, \$166 at physician offices, \$156 at urgent care centers, and \$570 at emergency departments."¹⁰⁴ The convenience of location and price coupled with the potential to save lives through preventive medicine will lead to a more healthy and productive workforce in the United States.

Retail clinics also provide patients with preventative care in addition to treating acute conditions.¹⁰⁵ Preventive care has proven to be a good investment. A study by the National Commission on Prevention Priorities found "preventive services such as daily aspirin use, tobacco cessation support and alcohol abuse screening can potentially save 2 million lives and

¹⁰¹ *Price Menu*, WALGREENS (2014), http://www.walgreens.com/topic/pharmacy/health_care-clinic/price-menu.jsp.

¹⁰² Donna Haybarger, *Employee Wellness Programs for a More Productive Workforce*, CORPORATE WELLNESS MAGAZINE (May 17, 2013), <http://oldsite.healthcarereformmagazine.com/article/employee-wellness-programs-for-a-more-productive-workforce.html>.

¹⁰³ Haugland & Hughes, *supra* note 7.

¹⁰⁴ Weinick et al., *supra* note 93.

¹⁰⁵ *Retail Health Care Clinics*, RAND CORPORATION, <http://www.rand.org/topics/retail-health-care-clinics.html> (last visited Mar. 13, 2015).

nearly \$4 billion annually.”¹⁰⁶ A nurse practitioner and manager of MinuteClinics in Virginia asserted, “[w]e catch a lot of things in people who just don’t go to the doctor. Maybe they have high blood pressure and don’t know it. A retail clinic is not equipped to manage chronic hypertension, but spotting the problem is a first step.”¹⁰⁷ The convenience and ease of access of RHCs will lead to millions of dollars saved, as many people will catch diseases before they progress due RHC preventive services.

Purported economic benefits are inevitably dependent upon perspective. From a patient’s perspective, the proliferation of RHCs holds the potential to provide health care at a lower price and induce competitiveness in the health care market. However, many primary care physicians have voiced discontent with retail clinics, proclaiming that RHCs are a financial threat that will negatively impact business.¹⁰⁸ Dr. Ted Epperly, head of the American Academy of Family Physicians stated, “[t]he most profitable part of a family physician’s practice is exactly what RHCs are going after.”¹⁰⁹

Although primary care physicians may lose business, as the number of patient visits at retail clinics is projected to account for ten percent of non-primary care outpatient visits by the end of 2015,¹¹⁰ this reduction in business may be a necessary curtailment of funds in the evolving health care market. A new report released by Accenture at the annual America’s Health Insurance Plans Institute 2013 in Las Vegas stated that, RHCs are “expected to drive \$800 million in annual cost savings by 2015 and will add capacity for 10.8 million patient visits per year, compared to 5.1 million in 2011.”¹¹¹ These impressive statistics are hard to ignore and prove the value

¹⁰⁶ Donya Currie, *Prevention Saves Lives as Well as Money, New Research Confirms*, NATIONS HEALTH (2010), <http://www.medscape.com/viewarticle/73524>.

¹⁰⁷ Kate Pickert, *Getting Well While You Shop*, TIME (June 11, 2009), http://content.time.com/time/specials/packages/printout/0,29239,1903873_1903925_1903791,00.html.

¹⁰⁸ Evan Grossman, *Where do Retail Health Clinics Fit Into the Market?*, ATHENAHEALTH (Oct. 30, 2013), <http://www.athenahealth.com/blog/2013/10/30/where-do-retail-health-clinics-fit-into-the-market/>.

¹⁰⁹ Pickert, *supra* note 107.

¹¹⁰ *U.S. RHCs Expected to Double by 2015, According to Accenture*, ACCENTURE (June 12, 2013), http://newsroom.accenture.com/article_display.cfm?article_id=5761.

¹¹¹ *Id.*

and necessity of retail clinics for the future of efficient health care in America.

VI. CONCLUSION

The ACA has instituted various changes aimed at repairing the broken health care system in the United States. In order to support the increased use of the health care system that will inevitably occur as a result of the ACA, changes in licensing legislation must be made. Non-physician medical professionals have been shown to provide quality care at a lower cost. RHCs are a mechanism to provide access to health services in the coming years when people would otherwise be waiting in lines for acute health care. State laws should be relaxed to minimize the required level of physician supervision at RHCs to optimize resources and save money. Economic protectionism, implemented by many state licensure boards, should no longer prevail. The health of U.S. citizens is at risk; expansion of scope of practice laws, relaxing physician supervision requirements at health clinics, and permitting increased use of telemedicine is necessary for the health care industry to be successful. As the barriers to health care are slowly broken down, provisions of the ACA can reach their full potential and ultimately save the lives of thousands of U.S. citizens.