American Academy of Physician Associates

May 22, 2025

Andrew N. Ferguson, Chairman
Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

RE: Request for Public Comment Regarding Reducing Anti-Competitive Regulatory Barriers - Attention: FTC-2025-0028-0001

Dear Chairman Ferguson,

The American Academy of Physician Associates (AAPA), on behalf of approximately 190,000 PAs (physician associates/physician assistants) throughout the United States, would like to provide comments on RFI FTC-2025-0028-0001, seeking input on reducing anti-competitive regulatory barriers, specifically those regulations that hinder market competition. AAPA seeks to work in partnership with the Federal Trade Commission (FTC) to identify regulations and policies that unnecessarily exclude market entrants, protect dominant incumbents, and predetermine economic winners and losers. PAs have long fought against such regulatory barriers that exclude PAs in favor of physicians, with no factual justification for such exclusion. It is within this context that we draw your attention to our comments.

PA Profession

PAs practice medicine in all 50 states and the District of Columbia, U.S. territories, and the uniformed services. PAs also practice in all medical specialties. As such, PAs are already well-positioned to increase access to care for millions of Americans, especially if certain unnecessary barriers in federal law and regulation are addressed. This ability will rapidly increase over the next few years, with the Bureau of Labor Statistics projecting the employment growth of PAs as being one of the fastest among all medical professionals at 28% from 2023 to 2033[1], compared to the

[1] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, Physician Assistants, at https://www.bls.gov/ooh/healthcare/physician-assistants.htm

employment growth of physicians at 4%.[2] Of the estimated 1.5 million practitioners in the U.S. in 2033, about 50% of them will be physicians and 50% will be PAs and other non-physician practitioners.[3] Further, a report stated, "This growth is not arbitrary but stems from the pivotal contributions these professionals make to our healthcare system."[4]

PA Education, Training, Qualifications

PAs undergo rigorous education and training to become board-certified and licensed to practice. There are more than 310+ nationally accredited graduate medical PA programs nationwide, in which PAs complete didactic education, laboratory instruction, and clinical rotations. With thousands of hours of medical education, PAs are highly qualified, capable, and versatile healthcare providers. The intensive PA curriculum is modeled on that used in medical school, and PA students often take classes or have clinical rotations alongside medical students.

The didactic phase of PA school provides a broad foundation in medical principles through instruction in the classroom and laboratory. In total, PA students complete more than 400 hours in basic medical sciences, more than 800 hours of clinical medical sciences, nearly 150 hours in behavioral and social sciences, 100 hours in pharmacology, 175 hours in research, and 125 hours in health policy and professional practice.[5] PA students complete at least 2,000 hours of clinical practice experience by graduation.[6]

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[2] Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, Physicians and Surgeons, at https://www.bls.gov/ooh/healthcare/physicians-and-surgeons.htm

[3] The 50/50 statistic comes from comparison of total number of providers from footnote 2 along with those of footnote 1 combined with: Bureau of Labor Statistics, U.S. Department of Labor, *Occupational Outlook Handbook*, Nurse Anesthetists, Nurse Midwives, and Nurse Practitioners, at https://www.bls.gov/ooh/healthcare/nurse-anesthetists-nurse-midwives-and-nurse-practitioners.htm

[4] Singh, L., & Gurjar, R., Insight Brief: The Increasingly Important Role of NPs and PAs in Healthcare Sales Targeting, IQVIA (April 26, 2024). Available at: https://www.iqvia.com/locations/united-states/library/insight-brief/the-increasingly-important-role-of-nps-and-pas-in-healthcare-sales-targeting

[5] Physician Assistant Education Association. By the Numbers: Curriculum Report 5: Data from the 2019 Didactic Curriculum Survey. 2020. doi: 10.17538/CR5.2020.

[6] Physician Assistant Education Association. Nineteenth Annual Report on Physician Assistant Educational Programs in the United States, 2002-2003. 2003. https://paeaonline.org/wp-content/uploads/imported-files/19th-Annual-Report-on-Physician-Assistant-Educational-Programs-in-the-United-States-2002-2003.pdf

Quality of PA Care

PAs produce results comparable to physicians in quality, outcomes, safety, and patient satisfaction.[7] The Medicare Payment Advisory Commission, an independent congressional agency that provides healthcare policy recommendations to Congress and the Secretary of Health and Human Services, concluded that "PAs provide care that is substantially similar to physicians in terms of clinical quality outcomes and patient experience." [8] PAs have also been shown to increase access to care,[9] improve care coordination, and decrease healthcare costs.[10]

PAs practice in all medical settings and specialties across the United States providing high-quality, patient-centered, and cost-effective care that benefits patients, employers, and the U.S. healthcare system.

Anticompetitive Barriers to PAs

Anticompetitive PA laws and regulations impede the full benefit that the healthcare system and individual consumers receive from PAs.

Removing anti-competitive barriers to PAs as a method of improving healthcare was identified during President Trump's first term and highlighted in Reforming America's Healthcare System Through Choice and Competition, a publication jointly authored by the Department of Health and Human Services, the Department of the Treasury, and the Department of Labor. Specifically, the

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[7] van den Brink GTWJ, Hooker RS, Van Vught AJ, Vermeulen H, Laurant MGH (2021) The cost-effectiveness of physician assistants/associates: A systematic review of international evidence. PLoS ONE 16(11): e0259183. https://doi.org/10.1371/journal.pone.0259183. *See also*, Yang Y, Long Q, Jackson SL, Rhee MK, Tomolo A, Olson D, Phillips LS. Nurse Practitioners, Physician Assistants, and Physicians Are Comparable in Managing the First Five Years of Diabetes. Am J Med. 2018 Mar;131(3):276-283.e2. doi: 10.1016/j.amjmed.2017.08.026. Epub 2017 Sep 8. PMID: 28893514; PMCID: PMC5817031. *See also*, CITE
Virani SS, Akeroyd JM, Ramsey DJ, Chan WJ, Frazier L, Nasir K, S Rajan S, Ballantyne CM, Petersen LA. Comparative effectiveness of outpatient cardiovascular disease and diabetes care delivery between advanced practice providers and physician providers in primary care: Implications for care under the Affordable Care Act. Am Heart J. 2016 Nov;181:74-82. doi: 10.1016/j.ahj.2016.07.020. Epub 2016 Aug 28. PMID: 27823696.
[8] Medicare Payment Advisory Commission. Report to the Congress. Medicare and the Health Care Delivery System. June 2019. https://www.medpac.gov/wpcontent/uploads/import_data/scrape_files/docs/default-source/reports/jun19_medpac_reporttocongress_sec.pdf
[9] Dower C, Christian S. Physician Assistants and Nurse Practitioners in Specialty Care: Six Practices Make It Work. California Health Care Foundation. 2009. https://www.chcf.org/wp-content/uploads/2017/12/PDF-NPPAModels.pdf
[10] Morgan PA, Smith VA, Berkoweitz SZ, et al. Impact of Physicians, Nurse Practitioners, and Physician Assistants on Utilization and Costs for Complex Patients. Health Affairs. 2019;38(6):1028-1036. doi: 10.1377/hlthaff.2019.00014.

publication, which was also in response to an Executive Order by President Trump, stated that "states should consider eliminating requirements for rigid collaborative practice and supervision agreements" between physicians and PAs or other practitioners "that are not justified by legitimate health and safety concerns." These recommendations were built on the foundation that PAs provide safe and effective care on the level of physicians.

The FTC's RFI placed a focus on anticompetitive regulations and policies that "operate to exclude new market entrants, protect dominant incumbents, and predetermine economic winners and losers." It goes on to state that "regulations that have the effect of reducing competition, entrepreneurship, and innovation—and thereby holding back the American economy—should generally be eliminated or modified."

The Academy has identified numerous regulations that serve to reduce competition by excluding PAs unnecessarily and with no factual basis. These regulations therefore reduce competition and may mean that not only is there an impact on the economy, but that consumers may be left without a choice between the most qualified and competent options to provide their healthcare. AAPA has therefore compiled the following categorized list of regulations that are currently barriers to PAs delivering high-quality care to millions of Americans.

Regulatory changes to ensure access to quality post-acute care.

- **Revise 42 CFR § 424.13(a), 42 CFR § 424.13(c)(1) and (2), 42 CFR § 424.13(d)(1) 42 CFR § 424.14, and 483.30 to authorize PAs to perform the initial and all required visits in a skilled nursing facility and approve in writing a recommendation that an individual be admitted to a facility.** 42 CFR § 424.13(a), 42 CFR § 424.13(c)(1) and (2), 42 CFR § 424.13(d)(1) 42 CFR § 424.14, and 42 CFR § 483.30 conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Additionally, PAs have been demonstrated to provide care that is comparable to physicians in quality, outcomes, and patient satisfaction. Amending these regulations will ensure access to quality post-acute care.

- **Revise 42 CFR § 412.29, 42 CFR § 412.622 (a)(4)(i)(D), 42 CFR § 412.622 (a)(4)(ii)(A), and 42 CFR § 412.622 (a)(5) to authorize PAs to provide all required face-to-face visits, review and improve the preadmission screening, and complete the plan of care in inpatient rehabilitation facilities (IRFs).** These

regulations conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Additionally, PAs have been demonstrated to provide care that is comparable to physicians in quality, outcomes, and patient satisfaction. Amending these regulations will ensure access to quality post-acute care.

- **Revise 42 CFR § 409.33(1)(i), (2)(ii), and (b)(7) to authorize care plans in IRFs to be based on PAs' orders.** These regulations conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State and with Sec. 1814(2) of the SSA for PAs to certify the need for post-hospital extended care services.

Regulatory changes to increase efficiency, improve workforce adequacy, and reduce administrative burden.

- **Revise 42 CFR § 418.106(b)(1)(iii) to authorize hospice-employed PAs to order medications for hospice patients.** 42 CFR § 418.106(b)(1)(iii) conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Further, non-hospice-employed PAs are authorized to order medications for hospice beneficiaries. Amending this regulation will improve efficiency and reduce administrative burden.

- **Revise 42 CFR § 485.631(b)(1)(iv) and 42 CFR § 485.631(b)(1)(v) to remove requirements that a physician periodically review and sign records of all inpatients seen by PAs in Critical Access Hospitals (CAHs).** Physician cosignature requirements are not generally required by state law and create inefficiencies and administrative burdens without benefiting patients.

- **Revise 42 CFR § 485.639(a) to authorize PAs to perform surgical procedures by including them in the list of "qualified practitioners" in CAHs.** 42 CFR § 485.639(a) conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State, including minor surgery. Amending this regulation will increase workforce adequacy and improve efficiency.

- **Revise 42 CFR § 485.524(d)(1) and 42 CFR § 485.528 to authorize PAs to perform surgical procedures by including them in the list of "qualified practitioners" in Rural Emergency Hospitals.** 42 CFR § 485.524(d)(1) and 42 CFR § 485.528 conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State, including minor surgery. Amending this regulation will increase workforce adequacy and improve efficiency.

- **Revise regulations to authorize PAs to provide services in Ambulatory Surgical Centers (ASCs).**

    - **Revise 42 CFR § 416.42 to authorize PAs to perform surgical procedures by including them in the list of "qualified practitioners" in ASCs.** 42 CFR § 416.42 conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i)) for PAs to provide "physicians' services" they are authorized to perform by the State, including minor surgery. Amending this regulation will increase workforce adequacy and improve efficiency.

    - **Revise 42 CFR § 416.42(a)(1)(i) and 42 CFR § 416.42(a)(1)(ii) to authorize PAs to evaluate risk in ASCs.** These regulations conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden.

    - **Revise 42 CFR § 416.48(a)(3) to authorize PAs to order drugs and biologicals in ASCs.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State, which includes prescriptive authority. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden.

    - **Revise 42 CFR § 416.52(c) to authorize PAs to perform essential discharge functions in ASCs.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 42 CFR § 410.10(e)(2)(1) and (ii) to authorize PAs to certify the need for nonemergency, scheduled, repetitive ambulance services.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 42 CFR § 485.914 and 42 CFR § 485.916 to be inclusive of PAs to perform certain requirements in community mental health systems.** These regulations conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending these regulations will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 21 CFR § 606.110(a)(1) and (2) to authorize PAs to determine when a recipient must be transfused with the leukocytes or platelets from a specific donor and supervise the procedure.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 21 CFR § 606.151(e) to authorize PAs to expedite transfusion in life-threatening emergencies and complete and sign documentation justifying the emergency action.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 21 CFR § 606.160(b)(1)(iv) to allow records to include signed requests from PAs for therapeutic bleedings.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise 21 CFR § 606.160(b)(3)(v) to authorize PAs to order and sign for the emergency release of blood.** This regulation conflicts with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to

perform by the State. Amending this regulation will increase workforce adequacy, improve efficiency, and decrease administrative burden.

- **Revise regulations under 8 USC 1222(b) and 8 CFR 232.2(b) that prevent PAs from being designated as civil surgeons who can perform medical examinations for immigrants seeking permanent resident status, or for immigrants detained for mental and physical examination.** Civil surgeons are designated by the Attorney General to provide routine physical examinations to immigrants seeking permanent resident status, or to immigrants who are detained for mental physical examination. Under 8 CFR 232.2(b), the civil surgeon designation is limited to physicians with no less than four years of experience. However, the responsibilities of a Civil Surgeon overlap substantially with the responsibilities of PAs. For example, PAs perform routine physical examinations, order and analyze lab results, and administer vaccinations, which is consistent with the duties of a civil surgeon. Removing anti-competitive barriers to broaden the range of highly trained and skilled providers who can be designated as civil surgeons will streamline the permanent residency process.

The Academy has also identified numerous sub-regulatory anti-competitive issues. Although the Office of the Attorney General issued a memorandum during President Trump's first term indicating that guidance documents "do not have the force and effect of law," many healthcare facilities rely on guidance documents to inform work practices. Sub-regulatory policies and guidance documents that are more restrictive than regulations and statutes can lead to inefficiencies, administrative burdens, and workforce inadequacies that adversely affect health and wellness. Therefore, AAPA urges the FTC to consider the below revisions to sub-regulatory documents to enable PAs to practice to the full extent of their license, improve the delivery of healthcare in the US, reduce federal spending on healthcare, and eliminate anticompetitive restraints on the profession:

Sub-regulatory changes to promote wellness and chronic disease management.

- **Revise the National Coverage Determination (NCD) for Colorectal Cancer Screening to authorize payment for Fecal Occult Blood Tests and Blood-based Biomarker Tests for colorectal cancer screening ordered by PAs**. The NCD is in direct conflict with the statutory authority of SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State, 42 CFR § 410.37(b) authorizing payment of FOBT ordered by PAs, and 42 CFR § 410.32 authorizing payment for diagnostic laboratory tests

ordered by PAs. Revising the NCD will improve screening, detection, disease prevention, and wellness.

- **Revise the NCD for home blood glucose monitors to authorize PAs to certify the need for coverage.** The NCD is in direct conflict with the statutory authority of SSA Sec. Sec. 1834 for PAs to order/certify durable medical equipment. Revising the NCD will improve chronic disease management.

- **Revise Section 290 of Chapter 15 of the Medicare Benefit Policy Manual to authorize coverage of podiatry services for beneficiaries with certain metabolic, neurologic, and peripheral vascular diseases when under the care of a PA.** The current policy requires patients to have been evaluated and treated by a physician. This requirement is not based on statute. Revising the policy will improve chronic disease management.

Sub-regulatory changes to increase efficiency, improve workforce adequacy, and reduce administrative burden.

- **Revise Section 40.1.3.3 Chapter 9 of the Medicare Benefit Policy Manual to authorize PAs employed by a hospice to serve in the role of a patient's attending physician if an "attending physician" was not previously selected by the patient.** The current policy requires a beneficiary who does not have a physician, nurse practitioner (NP), or PA who provided primary care to them prior to or at the time of terminal illness to select an "attending physician" who is a physician or NP (but not a PA). This policy conflicts with the statutory authority of the SSA Sec 1861(dd)(3)(B) that authorizes PAs to serve as "attending physicians" for hospice and SSA Sec. 1861(s)(2)(k)(i) for PAs to provide "physicians' services" they are authorized to perform by the State. Revising this policy will improve workforce adequacy, increase efficiency, and reduce administrative burden.

- **Revise the State Operations Manual Appendix Z to remove unnecessary physician co-signatures on discharge summaries.** The language in the manual (page 234) stating "Whether delegated or non-delegated, we would expect the person who writes the discharge summary to authenticate, date, and time their entry and additionally for delegated discharge summaries we would expect the MD/DO responsible for the patient during his/her hospital stay to co-authenticate and date the discharge summary to verify its content" should be

removed. Physician cosignature requirements are not generally required by state law and create inefficiencies and administrative burdens without benefiting patients.

- **Revise Section 30.6.9.2 B and E of Chapter 12 of the Medicare Claims Processing Manual to indicate that PAs may perform and bill for hospital discharge management and death pronouncements.** Physician-centric language should be modified to indicate that PAs can pronounce death and are authorized to bill discharge management services (CPT 99238 or 99239) to Medicare. PAs have the statutory authority in SSA Sec. 1861(s)(2)(k)(i) to provide "physicians' services" they are authorized to perform by the State. Modifying the language will improve workforce adequacy, decrease inefficiencies, and remove administrative burden.

- **Revise Section 30.6.7 of Chapter 12 of the Medicare Claims Processing Manual and/or claims processing methods to improve the efficiency of payment for Office or Other Outpatient Evaluation and Management Services.** Medicare policy related to "new versus established patients" and "same day services," as well as all PAs being recognized by the same taxonomy on claims forms, leads to the **i**nappropriate denials of claims and subsequent overturning of those denials through the appeals process. Policies and/or processes should be modified to improve efficiency and administrative burden.

- **Revise policies to allow for the payment of minor procedures performed by PA students under the direct supervision of a billing practitioner (e.g., a PA or physician).** There is no authorization for the payment of minor procedures (e.g., sutures, excisional biopsy, and injections) performed by PA students under the direct supervision of a licensed practitioner (after the need for the procedure is determined appropriate by a licensed practitioner) as there is for minor procedures performed by medical residents under the direct supervision of "teaching physicians". Policies should be amended to ensure appropriate training for PAs to improve workforce adequacy.

- **Revise policies to allow PAs to practice to the full extent of their education, training, and experience and in a manner that standardizes the profession's practice in all Department of Veterans Affairs (VA) medical facilities**. In November of 2020, the VA issued a rule (38 CFR Part 17) affirming that healthcare providers may practice in a manner consistent with the scope and requirements of their VA employment, notwithstanding any state license, registration, certification, or other requirements that unduly interfere with their practice. AAPA strongly supported this rule, as it has the potential to increase

competition and expand access to quality provided by PAs. This rule also makes clear that VA has the authority to grant full practice authority and licensed independent practitioner (LIP) status to PAs working at the VA. To fully maximize the potential of this rule, stripping away anti-competitive practice restrictions is imperative to ensure the PA workforce at the VA is in the strongest position to continue serving veterans and to expand access to high-quality care for our nation's veterans.

- **Revise policies to ensure PAs can be designated as Aviation Medical Examiners (AME) by the Federal Aviation Administration (FAA)**. Under 14 CFR 183.11, the Federal Air Surgeon, or their authorized representatives within the FAA, may designate AMEs who are given the authority to accept applications and perform physical examinations necessary to determine qualifications for the issuance of second and third-class FAA airman medical certificates under 14 CFR 6. PAs conduct health assessments and certify the health status of individuals in many other settings, including in other parts of the federal government, such as in the US military. Ensuring PAs can be designated as Aviation Medical Examiners would remove an anti-competitive barrier that makes it more difficult to certify the health of civil aviators, keeping pilots unnecessarily grounded.

  The FAA's unnecessary limitations on who may be designated as an AME also affects military readiness. Military pilots also require flight physicals to ensure they meet the physical and mental standards required for safe flight operations, but military surgeons general have followed the lead of the FAA in who can perform flight physicals. Aeronautical PAs in the military already down pilots from flying, return them from flying duties, and are generally able to complete every aspect of their mission to take care of aircrews. But as long as the military is following FAA's regulation of AMEs, PAs cannot perform flight physicals, thus making it more difficult and expensive to keep military pilots safe, healthy, and able to defend our nation.

In summation, AAPA urges the FTC to address the above barriers and eliminate anticompetitive regulations and policies impeding PAs from delivering high-quality, safe care to patients. As evidenced above, PAs have the proven requisite education, training, and experience to safely and efficiently provide care.

Request for Update to Use of the PA Profession Title

In addition to the above-identified regulations and policies, AAPA requests that all references to PAs in regulations, and policies be listed as "Physician Associates/Physician Assistants", as recognized in 20 CFR § 220.46 (a)(9).[11] This accurately reflects PAs who currently graduate with degrees as either "physician assistant" or "physician associate" and are state-licensed as a "physician assistant" or "physician associate," but who all graduate from programs accredited by the same accrediting organization (ARC-PA), are certified by the same certifying organization (NCCPAs), and have the same scopes of practice. Although the profession has been known as "physician assistant," the official title of the profession is now recognized as "physician associate" to more accurately reflect the breadth of education, training, experience, and services of PAs. This is reflected in the title of the AAPA, other professional organizations,[12] professional training programs,[13] and state and territory laws and licensure.[14] Despite the recognized title of "physician associate," it is anticipated to take some time for the title change from "physician assistant" to occur in all states and jurisdictions in which PAs practice. Therefore, a dual reference to "physician assistant" and "physician associate" is recommended to avoid confusion. AAPA urges the FTC to reference the profession by the dual title "physician assistant/physician associate."

AAPA urges the FTC to properly refer to the PA profession as "physician assistants/physician associates" in all official documents.

[11] Code of Federal Regulations: Medical evidence. 20 CFR § 220.46. 2025. https://public-inspection.federalregister.gov/2025-00515.pdf

[12] Several Constituent Organizations, which are independent organizations affiliated with AAPA, have reflected the title Physician Associate in their professional organization's legal name. Examples: Connecticut Academy of Physician Associates https://connapa.org/aboutconnapa, Kansas Academy of Physician Associates https://kansaspa.mypanetwork.com, Academy of Physician Associates in Cardiology https://www.cardiologypa.org, and Association of Physician Associates in Obstetrics and Gynecology https://apaog.wildapricot.org.

[13] Several universities, which are accredited by the Accreditation Review Commission on Education for the Physician Assistant (ARC-PA), have Physician Associate Programs and graduate students in Physician Associate Studies. Examples: Yale School of Medicine, Physician Associate Program, https://medicine.yale.edu/pa, Wichita State University, Physician Associate Program https://www.wichita.edu/academics/health_professions/pa/, Alvernia University, Physician Associate Program https://www.alvernia.edu/academics/ug/bio-pa.

[14] Oregon Governor Tina Kotek Signs Law Changing PA Title (April 5, 2024) https://www.aapa.org/news-central/2024/04/oregon-governor-tina-kotek-signs-law-changing-pa-title/. See also, Or. Rev. Stat. § 677. See also, Wis. Stat. § 448.974(1)(a)(2)-(6). See also, 185 N. MAR. I. ADMIN. CODE § 185-10-4101(p).

State Anticompetitive Issues

In addition to federal regulations, we also write to provide you with information on how PAs face competitive restrictions in both legislation and regulation, including under medical and healing arts boards, in various states.

According to a recent report of the Association of American Medical Colleges, it is anticipated that the U.S. will experience a shortfall of up to 86,000 primary care physicians by 2036.[15] Given this report, the Bureau of Labor Statistics projected employment growth of the profession, and the projected increase in the demand for primary care services by 1.4% annually through the year 2029,[16] PAs are part of the solution and necessary to help ensure patients have access to timely, quality healthcare.

PAs provide care to their patients from birth and throughout their lives. The broad generalist focus of PA education allows PAs to provide quality care for the whole patient and be a one-stop provider for patients who lack easy access to medical care. Ninety-eight percent of PAs are practicing clinically in their primary role and see a median of 15 patients per day and 60 patients per week.[17] The patients PAs see frequently represent complex cases with 50% of their patients having 2 or more comorbidities.[18]

PA-provided care is especially critical in rural and medically underserved areas, where PAs may serve as the only healthcare professional available. Some states authorize PAs to own and manage their own medical practices.

PAs embrace new models of care. Patients utilize urgent care and retail clinics, which are open after business hours and on weekends, allowing patients to access care without taking time off from work. This degree of consumer choice allows for patient cost savings. PAs are an important part of the urgent care and retail clinic workforce, and are also increasingly practicing using telemedicine, another vehicle for extending care without requiring patients to travel long distances or take extended time off from work. The ability of PAs to provide patient education and to improve outpatient access to care can decrease emergency department visits, another cost savings to

[15] GlobalData Plc. The Complexities of Physician Supply and Demand: Projections From 2021 to 2036. Washington, DC: AAMC; 2024. https://www.aamc.org/media/75236/download?attachment
[16] Jain, Sanjula, Narrowing Primary Care Gap Requires Predicting Demand and Consumer Behavior. The Compass. November 21, 2021 https://www.trillianthealth.com/market-research/studies/narrowing-primary-care-gap-requires-predicting-demand-and-consumer-behavior
[17] American Academy of PAs. (2025) 2025 AAPA Salary Survey. Alexandria, VA.
[18] American Academy of PAs. (2023). 2023 AAPA PA Practice Survey. Alexandria, VA.

patients and to the healthcare system. PAs are most beneficial to patient cost savings and able to avail themselves of these models of care when not restricted by arbitrary scope of practice and oversight barriers.

The PA profession has long believed that the best medicine is practiced in teams. Every clinician does and should collaborate, consult with, and refer to other providers when indicated by the patient's condition, the education and experience of the clinician and the standard of care. Effective communication between clinicians improves patient care. PAs continue to embrace this model. However, nothing is gained by requiring that PAs have or report a specific relationship with a physician or group of physicians in order to practice. These requirements, included in state laws when PAs were a novel and untested profession, unnecessarily burden physicians with increased liability and administrative inconvenience. As physicians are increasingly practicing in groups and as employees rather than employers, they are reluctant to sign supervision or collaboration agreements with PAs, as they experience no personal economic benefit from doing so. PAs should be able to practice in teams with physicians in hospitals or clinics without needing to designate a specific physician as a collaborator and seeking physician input as required by the clinical situation. Currently, only seven states (Iowa, Montana, New Hampshire, North Dakota, South Dakota,[19] Utah and Wyoming) have eliminated the requirement for a PA to have a specific relationship with a physician to practice.

Like every other health professional, PAs should have meaningful input into regulation of the profession. In many states, the PA profession is at heightened risk for unnecessary restrictions due to anticompetitive activity including from legislatures and state medical boards. Except for ten states, which have separate PA boards with regulatory authority (Arizona, California, Iowa, Massachusetts, Michigan, Rhode Island, Tennessee, Texas, Utah, and Wisconsin), PAs are regulated by medical boards which are composed of a majority of physician market participants. Even among these ten states, not all of the PA boards have plenary authority over the profession; some aspects of PA regulation such as determining scope of practice or disciplinary actions for violations involving prescribing, dispensing, or otherwise issuing a controlled substance must be done in conjunction with the medical board. The rest of the states regulate PAs through medical or healing arts boards.

Of the states where PAs are regulated by medical or healing arts boards, sixteen have established PA advisory committees or councils. While the scopes of these boards vary, they typically make recommendations to the board on license approval for PAs, education requirements, and

[19] South Dakota's new law pursuant to the enactment of HB 1071 becomes effective on July 1, 2025.

disciplinary actions. They also advise the board on rule changes necessary to license and regulate PAs. Currently, 25 states have a designated PA seat (in some states, multiple seats) on the medical licensing board. While the bulk of PAs participate fully in the medical board decision-making process, exceptions exist. For example, the Georgia medical board PA appointee serves ex officio, with full voting privileges only on PA issues. In Kentucky, the chair of the PA Advisory Committee also serves as the PA ex officio nonvoting member of the medical board. In New York, participation of the two PA members is limited to PA matters and South Dakota precludes PAs from participating in discussions on, being present for discussions of confidential matters, and acting on matters relating to the licensure, practice, education, continuing education, investigation, and discipline of physicians.

The PA profession is at heightened risk for unnecessary restrictions due to anticompetitive activity from state medical boards that lack meaningful input from professionals knowledgeable about PA practice. This situation is not dissimilar to *NC Dental Board*,[20] where a board of market participants illegally restricted services and consumer choice. The PA profession historically and currently faces scope of practice limitations and unnecessary oversight mandates that limit PAs. For example:

- In **Alabama** and **Georgia**, the state medical boards must not only approve the supervising physician(s) with whom the PA will practice but also the PA's scope of practice with that designated supervising physician. PAs in either state may not begin to work or provide patient care until they have received official notification in writing from the medical boards indicating their approval of both the supervising physician and the PA's accompanying scope of practice. As a result, neither state allows for flexible or customized care to be determined at the practice level, which leads to inefficiencies and limits access to care.
- **Florida** law imposes supervisory and proximity requirements on physicians who supervise PAs (and advanced practice registered nurses (APRNs) at medical offices other than the physician's primary practice location (the address reflected on the physician's profile submitted to the Florida Department of Health) where the PA or APRN is not under the onsite supervision of the supervising physician. A physician who is engaged in providing specialty health care services may not supervise more than two offices in addition to the physician's primary practice location. Greater barriers are imposed pertaining to dermatology. In that instance, a physician who supervises a PA or APRN at a practice that is not the physician's primary place of practice and that offers primarily dermatologic or skin care services, must be within 25 miles of the physician's primary place of practice or in a

[20] *N.C. State Bd. Of Dental Exam'rs v. FTC*, 135 S. Ct 1101, 1114 (2015).

county that is contiguous to the county of the physician's primary place of practice. Physicians engaged in dermatologic, or skin care services may only supervise one office other than the physician's primary place of practice.

- Prescribing medications, including Schedule II-V controlled medications, is integral to the practice of medicine. **Georgia**, **Kentucky**, and **Missouri** are outlier states that restrict PA prescriptive authority, thereby limiting patient access to care. With regard to Schedule II controlled medications, PAs in Georgia and Missouri, may only prescribe those containing hydrocodone or compounds thereof; in Kentucky PAs are completely barred from writing prescriptions for any Schedule II medication. All PAs are required to complete extensive training in pharmacology as a part of their education. Laws should authorize PAs to prescribe all legal medications, including controlled medications in the Drug Enforcement Administration's Schedules II-V, non-controlled medications, and devices. Laws that restrict PA prescriptive authority may cause interruptions in patient care. If a patient seen by a PA requires medication that PAs are prohibited from prescribing, then both patient and clinician are forced to take extra steps to ensure the patient receives the medication, which can result in additional costs to the system.

As with APRNs, PAs face competitive restraints in legislation, but those restraints are often heightened due to the more direct relationship between physicians and PAs. Distinctly though from APRNs, PAs are normally regulated under medical boards composed of self-interested market participants, and too often their regulation of PAs lacks an evidence basis. With the benefits of healthcare reform for patient choice, access and cost, competitive pressures on health care providers has often resulted in state board actions that place PAs in a constrained and disadvantaged position to practice to the full ability of the profession.

Differences between PAs and APRNs

In the clinical setting, PAs and ARPNs assume many of the same roles, so many of the studies on quality and cost effectiveness include PAs and APRNs together. However, there are three key differences. These include the educational model, the historic tie to physicians, and the regulatory model.

As noted in their title, APRNs are nurses who advance their practice upon additional education. APRN programs are taught in schools of nursing and have a nursing theory basis in approach to the

delivery of care. Additionally, APRNs are divided into four distinct roles, nurse anesthetist, nurse midwife, nurse practitioner, and clinical nurse specialist. For nurse practitioners, education and licensure occur in specified areas of role and population foci. These include Family, Adult/Gerontology, Neonatal, Pediatrics, Women's Health, and Psychiatric/Mental Health.

In contrast, PA programs follow the medical school model and are housed in academic medical centers, teaching hospitals, colleges, universities, and through the military. Incoming PA students bring with them a wealth of patient care experience—an average of more than 3,000 hours of direct patient contact experience[21]—in such jobs as paramedic, athletic trainer, or medical assistant.[22] Additionally, to enter a PA program, students must be prepared in undergraduate education through basic science and behavioral science coursework similar to the pre-medicine curriculum. PAs all train and graduate as medical generalists and derive their specialty and accrue additional skills through advanced training in the clinical setting, continuing medical education, and for some PAs, through formalized postgraduate programs.

Nursing has long been an autonomous, self-governing profession, and this identity has extended into its advanced practice. Historically, PAs have supported a clinical collaboration with physicians. Now with more than a 50-year history, the concept of team practice has expanded, and the clinical autonomy of PAs is increasingly recognized. While the PA profession retains its commitment to team practice, it opposes practice limitations imposed by non-evidence-based state and federal laws and regulations.

PAs are similar to APRNs in substance and practice, but different structurally and in how they are regulated. APRNs are regulated by boards of nursing, with a few notable exceptions where regulation is done jointly with a medical board. As noted, except for ten states, PAs are regulated by state medical boards. This subjects the PA profession to a physician (competitor) regulatory structure, unlike that of the APRNs.

The FTC notes in *Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses*, that "particular supervision requirements can burden, rather than facilitate, team-based care."[23]

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[21] Physician Assistant Education Association, By the numbers: Program report 36: Data from the 2021 program survey, , page 56. Washington, DC: PAEA; 2021.
[22] Physician Assistant Education Association, By the numbers: Student report 6: Data from the 2022 matriculating student and end of program surveys. Table 52, page 35. Washington, DC: PAEA; 2024.
[23] Gilman, D.J. and Koslov, T.I. (2014) Policy Perspectives: Competition and the Regulation of Advanced Practice Nurses. Federal Trade Commission. https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf

And the FTC questions "whether evidence supports a statutory mandate for some particular model of team-based care that is always led by a primary care physician"[24] and "whether evidence supports the contention that patients receive substandard care, or are harmed, when the law does not impose specific supervision requirements on APRNs and their patients."[25] These same policy questions, exacerbated by the PA profession's regulatory structure, apply to PAs.

Determining PA Scope of Practice

Scope of practice is a term used to describe the types of services a healthcare practitioner can provide. It is important to recognize the difference between professional scope of practice and legal scope of practice. Professional scope of practice is a profession's description of the services its members are trained and competent to perform. Legal scope of practice is a term often used by states and other jurisdictions to define, and restrict, the activities of a licensed health professional.

Type	Definition	Notes
Legal	• Authority granted by law • Restrictions in law	Generally, this scope is rigid in nature and affects all PAs equally.
Professional	What a PA may or may not do based on: • Education • Experience • Employer or facility credentialing • Healthcare team determinations • What a third-party payer will reimburse • What a liability insurer will insure • Professional ethics	No two PAs will have the same professional scope and the scope will change over time as these factors (and other influences) change.

Each state has laws, licensing bodies, and in most cases, regulations that describe requirements for education and training, and legal scope of practice. Additionally, a narrower governing body, such

[24] *Id.*
[25] *Id.*

as a hospital or clinic, may refine the scope of practice for the individual practitioner, further limiting the licensee's scope to a specific range of services or specific procedures. At the practice level, a physician and PA will define a proper scope of practice and any supervision.

Ideally, the PA legal scope of practice should authorize all aspects of professional scope of practice and should include any legal procedure for which the PA is prepared by education and experience, consistent with the needs of the patient population and is authorized by any applicable licensed facility through its credentialing and privileging system. Today, although 41 states and the District of Columbia now allow PA scope of practice to be determined at the practice level, a concept that mirrors professional scope of practice, some states still restrict certain aspects of PA practice and others require medical board approval of PA scope. Neither is acceptable and both, universally, have anticompetitive implications.

PAs as part of the Healthcare Team

PAs and physicians both practice medicine, and as such will by definition practice in concert. Historically, the PA profession was created to address a physician shortage and supplement the work of physicians through the physician profession delegating functions to the newly created PA profession. However, the evolution of healthcare delivery systems, as well as the evolution of PA education and training, has rightfully moved the profession well beyond the "delegated extender" role. PAs now function in leadership roles, including leading patient care teams in patient-centered medical homes. Collaborating with physicians and others, PAs are part of accountable care organizations. Some PAs are practice owners, collaborating with physicians as required by law and by the needs of individual patients. This expansion of the PA role has been accelerated by healthcare reform.

When the PA profession began, typically, a PA practiced with a single physician, small medical group, or in a hospital. Because the new profession had no track record to assure regulators of their excellent training or quality, practice laws were written with built-in precautions, such as designated physician supervisors and no prescriptive authority.

Over time, countless studies documented the high-quality medical care and expanded access PAs provide. As the evidence of high quality and safety became clear, legislators realized that supervision laws were too restrictive. They began updating laws, allowing PAs and physicians to

practice in separate locations, authorizing PAs to prescribe, and allowing individual teams to define their practices. Studies confirm that quality remains high.

Despite early laws that defined physicians and PAs in an employer-employee or supervisor-worker relationship, the most effective teams have always been collaborative and collegial. The model works best when PAs and physicians decide how they will practice together and when PAs are appropriately treated as competent and skilled professionals. When practicing most effectively and efficiently, PAs make autonomous decisions about patient care. If they reach the limits of their expertise, like any other medical provider, they consult someone who has the necessary expertise.

Like legal scope, how PAs and physicians will work together professionally should not be rigidly defined in law – or arbitrary requirements foisted on it – without evidence that those requirements protect the public and may not be achieved by other means. Like professional scope, the details of team practice should be determined by PAs and physicians at the practice level. When PAs and physicians are burdened by extensive oversight requirements, patient access to care is diminished. When the relationship between PAs and physicians is strictly defined or limited in law or regulation, or subject to medical board approval, too often competitive interests are promoted to the detriment of PAs and patient access.

PAs and the Healthcare Landscape

PAs are vital members of the healthcare team who serve many different roles. PAs serve as primary care providers, specialists, and first assistants during surgery, and can practice in every specialty in every setting. The PA profession has great flexibility, and PAs are able to meet the ever-changing needs of patients and health systems.

As more individuals enter into the Medicare program and physician shortages continue to worsen, obtaining appropriate and timely access to care is likely to become even more challenging for this patient population. PAs are an essential part of the healthcare delivery system and will, if not impeded by inefficient and restrictive rules and regulations, continue to improve access to care within the Medicare program.

The health system finds particular value in delivery models that seek to expand care options for patients, improve patient outcomes, and recognize the ability of health professionals to practice to the full extent of their education, expertise, and experience. As a national physician shortage

continues to worsen, health professionals who are qualified to oversee activities and treatments previously reserved only for physicians will help fill the gap and improve access to care.

PAs are also critical to containing healthcare costs. A 2002 study found that for every medical condition managed by PAs, the total episode cost was less than similar episodes managed by a physician.[26] A study published in 2008 based on analysis of Medicare's Medical Expenditure Panel Survey (MEPS) data found adult patients who saw PAs for a large portion of their yearly office visits had, on average, 16% fewer visits per year than patients who saw only physicians.[27]

The ability to control costs is limited by restrictive practice laws and regulations. In research published in 2015 in *Nursing Economics,* a cost analysis was undertaken to determine how changing restrictive practice laws would impact the cost of care.[28] The authors' case study focused on the state of Alabama because of its restrictive PA and NP laws. The cost analysis found that even modest changes to Alabama PA and NP laws would result in a net savings of $729 million over a 10-year period. Underutilization of PAs and restrictive state laws inhibit the cost benefits of increasing the supply of PAs.[29]

The Hallmarks of Ideal PA Regulation

Ideal state regulation of PAs authorizes the full practice of PAs while retaining the state's ability to set grounds for licensure and discipline, and impose disciplinary action when appropriate. AAPA has identified Six Key Elements of a Modern PA Practice Act. These include:

- Licensure used as the regulatory term for PAs
- Full prescriptive authority (ability to prescribe Schedule II-V controlled medications and all legend drugs)
- Scope of practice determined at the practice
- Adaptable collaboration requirements (no specification for a PA and physician to practice on-site together or within a specific proximity)

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[26] Hooker, R.S. (2002). Cost analysis of physician assistants in primary care. Journal of the American Academy of Physician Assistants, 15(11):39-50.
[27] Morgan, P.A., Shah, N.D., Kaufman, J.S., & Albanese, M.A. (2008). Impact of physician assistant care on office visit resource use in the United States. Health Services Research, 43(5 Pt 2):1906- 1922.
[28] Hooker, R.S. & Muchow, A.N. (2015). Modifying state laws for nurse practitioners and physician assistants can reduce cost of medical services. Nursing Economic$, 33(2):88-94.
[29] *Id*.

- No chart co-signature requirement
- No restriction on the number of PAs and physicians who may practice together

The pursuit of these elements in state law and regulation has been an advocacy goal of AAPA since 2008, working in concert with state PA associations. Their achievement, while steady, has been far from uniform. Today, only 17 states have attained all six elements.[30] In 2016 the first of the Six Key Elements was universally achieved when licensure became the regulatory term in all 50 states and the District of Columbia. Forty-seven states and the District of Columbia authorize full prescriptive authority for PAs, and as noted, 41 states and the District of Columbia allow scope of practice to be determined at the practice level. Thirty-nine states and the District of Columbia authorize plans for collaboration to be determined at the practice and forty-one states, and the District of Columbia have abandoned a co-signature requirement. Seventeen states have achieved all the Six Key Elements, while three states (Alabama, Louisiana, and Missouri) have only two. The most difficult Key Element to achieve and perhaps the one with the most anticompetitive motivation is the restriction of the number of PAs with whom a physician may collaborate. To date, only 23 states have no such restriction.

In addition to the Six Key Elements, AAPA supports the idea that licenses should be issued as a ministerial act. Some states require a personal interview of all potential licensees or go so far as to require that a PA report a collaborating physician as a condition of being issued a PA license. In a time when there is a recognized physician shortage, it is indefensible to deny a qualified PA a license because no physician is designated. Also, we believe that collaboration more accurately defines how PAs and physicians work together than the use of the term supervision. And we no longer support the concept that physicians should be responsible for PA-provided care or that the scope of practice should be tied to physician scope or determined by physician delegation. Last, the preferred model for a state PA regulatory agency is an independent PA licensing board.

Conclusion

PAs want to provide the care they are trained to deliver, and their patients need and deserve. PAs want to do this by practicing at the top of their education and experience, consistent with their training and competence, and unencumbered by arbitrary restrictions. The PA profession was

[30] For ease, South Dakota is included in this count as it will have attained this goal effective July 1, 2025 via the enactment of HB 1071.

established within a regulatory structure that almost guaranteed competitive pressures would influence its regulation. Historically, medical boards, often due to pressure from state medical societies, have limited PA practice, alleging it was necessary to do so to fulfill their mandate to "protect the public." There is no evidence to support the concept that limiting a PA's scope of practice or imposing oversight mandates improves care. In fact, it does just the opposite by limiting access, stifling innovation, and decreasing consumer choice. AAPA plans concerted advocacy to counter these forces.

PAs face a host of restrictions, and we hope for the FTC's assistance on policy and enforcement actions as we identify and address anticompetitive issues in the regulation of the PA profession.

Thank you for the opportunity to provide comments regarding anticompetitive barriers impacting PA utilization and delivery of care. AAPA welcomes further discussion with the FTC regarding this vitally important issue. For any questions you may have, please do not hesitate to contact Sondra DePalma, AAPA Vice President of Reimbursement & Professional Practice, at sdepalma@aapa.org.

Sincerely,

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