UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Economics
Bureau of Competition
Bureau of Consumer Protection

May 29, 2008

Hon. Elaine Nekritz
State Representative
State of Illinois – 57th District
24 South Des Plaines River Road
Des Plaines, IL 60016

Dear Representative Nekritz:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, Bureau of Consumer Protection, and Bureau of Competition[1] are pleased to respond to your invitation for comments regarding Illinois House Bill 5372 (HB 5372 or the Bill) and the proposed regulation of retail health care facilities in Illinois.[2] You ask whether HB 5372 "contains provisions that would be considered anticompetitive." In particular, you express concern about the Bill's prohibition of the location of a retail health care facility "in any store or place that provides alcohol or tobacco products for sale to the public."

Store-based health clinics – offering a small, fixed, and publicized range of basic health care services[3] – have the potential to expand access to health care by making very basic medical care convenient and less costly.[4] Retail clinics are often able to lower

[1] This letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, Bureau of Consumer Protection, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission (Commission) or any individual Commissioner. The Commission has, however, voted to authorize us to submit these comments.

[2] Letter from the Hon. Elaine Nekritz to Maureen K. Ohlhausen, Director, Office of Policy Planning, Federal Trade Commission (Apr. 9, 2008) (regarding Illinois House Bill 5372, 95th General Assembly 2007-08).

[3] Typical services include, e.g., common adult vaccinations, basic triage and diagnosis, and basic treatment of certain common ailments. *See generally* William Sage, *The Wal-Martization of Health Care*, 28 J. OF LEGAL MED. 503, 504-7 (2007) (Describing the typical conditions LSCs treat and their physical design located in retail settings); Mary Kate Scott, *Health Care In the Express Lane: Retail Clinics Go Mainstream*, Prepared for California Health Care Found. (Sept. 2007), *available at* http://www.chcf.org/topics/view.cfm?itemID=133464; Richard Bohmer, THE RISE OF IN-STORE CLINICS – THREAT OR OPPORTUNITY, 356 NEW ENG. J. MED 765 (Feb. 22, 2007).

[4] The American Medical Association has noted significant growth in what it terms store-based health clinics – generally located in pharmacies, shopping malls, and retail stores, and often staffed by nurse practitioners and/or physician assistants – and has stated that, "[i]n general, store-based health clinics are

costs – and prices charged to consumers – by offering a fixed, limited range of services in existing retail settings.[5] The use of a small leased space in an extant retail setting has been identified as a particular factor in the lower cost structure of such clinics that tends to reduce the prices they charge.[6]

The legislature's attention to such clinics is therefore commendable. At the same time, the FTC staff believes that certain provisions in HB 5372 need clarification because certain interpretations of those provisions could excessively restrict retail clinics to the detriment of Illinois health care consumers.[7] In addition, because several of the Bill's requirements would pertain only to retail clinics – and not other health care facilities offering the same services or staffing – those requirements could put retail clinics at a competitive disadvantage without offering countervailing consumer benefits.

Interest and Experience of the Federal Trade Commission

The FTC is charged under the FTC Act with preventing unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[8] Section 12 of the FTC Act specifically prohibits the dissemination of false advertisements for foods, drugs, devices, services, or cosmetics.[9]

Anticompetitive conduct in health care markets has long been a target of the FTC's law enforcement mission.[10] The FTC and its staff also have investigated the competitive effects of restrictions on the business practices of health care providers. In 2003, the FTC and the Department of Justice Antitrust Division held twenty-seven days

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able to fulfill the immediate needs of patients with minor conditions with less waiting time, more flexible evening and weekend hours, and in some cases, lower out-of-pocket expenses." American Medical Association, Report 7 of the Council on Medical Service (A-06), Store-Based Health Clinics 1 (June 2006) [hereinafter Council on Medical Service Report].

[5] *See, e.g.*, Mary Kate Scott, *supra* note 3, at 4-5; William Sage, *supra* note 3, at 504-07.

[6] Mary Kate Scott at 4.

[7] The Section 45 prohibition mentioned in your letter is one such restriction, as hospitals, pharmacies, and physicians' offices do not appear to be similarly restricted under Illinois law. Others include, for example, restrictions on truthful and non-misleading advertising (HB 5372 § 105) and certain "operating requirements" that would be imposed only on retail health care facilities, such as the requirement that each facility's staff include a receptionist (*id.* at § 35(4)) and the limit on the number of clinic affiliations for medical directors (*id.* at § 25(a)(4)).

[8] Federal Trade Commission Act, 15 U.S.C. § 45.

[9] FTC Act, 15 U.S.C. § 52.

[10] *See* FEDERAL TRADE COMMISSION, FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (Mar. 2008), *available at* http://www.ftc.gov/bc/0608hcupdate.pdf; *see also* FEDERAL TRADE COMMISSION, FTC ANTITRUST ACTIONS IN PHARMACEUTICAL SERVICES AND PRODUCTS (Mar. 2008), *available at http://www.ftc.gov/bc/0608rxupdate.pdf*; Competition in the Health Care Marketplace: Formal Commission Actions, *available at http://www.ftc.gov/bc/healthcare/antitrust/commissionactions.htm*. For a general overview of enforcement actions, including merger review in pharmaceuticals and health care markets, see Federal Trade Commission, Bureau of Competition Antitrust Enforcement Activities, Fiscal Year 2003-February 29, 2008, *available at* http://www.ftc.gov/bc/0608rxupdate.pdf.

of hearings on health care and competition law and policy.[11] In 2004, the FTC and the Antitrust Division jointly released a report – based on those hearings, an FTC-sponsored workshop, and independent research – that covered diverse issues in health care competition and delivery.[12]

FTC has also used its law enforcement authority to maintain the integrity of health care advertising. From April 2006 through February 2007, the FTC initiated or resolved thirteen law enforcement actions involving allegedly deceptive health claims.[13] The Commission and its staff have also undertaken research and advocacy directed specifically at health care advertising issues.[14] Those activities, like the hearings and report,[15] emphasized the importance of access to truthful and non-misleading health care marketing information to consumers. The FTC has sought to limit the anticompetitive and anti-consumer effects of unnecessary restrictions on truthful and non-misleading advertising by, among others, physicians,[16] chiropractors,[17] and optometrists.[18]

The FTC has also examined the emerging retail or limited service clinic market. These clinics were the focus of a panel at a recent FTC public workshop.[19] Last year, FTC staff submitted comments on draft Massachusetts regulations regarding limited service clinics. The draft regulations recognized that new models of health care delivery

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[11] Federal Trade Commission and Department of Justice, Joint Hearings on Health Care and Competition Law and Policy (2003). Links to transcripts and other hearings materials are available at http://www.ftc.gov/bc/healthcare/research/healthcarehearing.htm.

[12] Federal Trade Commission and Department of Justice, IMPROVING HEALTH CARE: A DOSE OF COMPETITION Chapter 7 (2004) [hereinafter A DOSE OF COMPETITION], *available at* http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[13] *See, e.g.*, *FTC v. Window Rock Enters., Inc.*, No. CV04-8190 (JTLx) (C.D. Calif. filed Jan. 4, 2007) (stipulated final orders) (Cortislim), *available at* http://www.ftc.gov/os/caselist/windowrock/windowrock.htm*; In the Matter of Goen Techs. Corp.*, FTC File No. 042 3127 (Jan. 4, 2007) (consent order) (TrimSpa), *available at* http://www.ftc.gov/os/caselist/goen/0423127agreement.pdf; *United States v. Bayer Corp.*, No. 07-01 (HAA) (D.N.J. filed Jan. 3, 2007) (consent decree) (One-A-Day), *available at* http://www.ftc.gov/os/caselist/bayercorp/070104consentdecree.pdf.

[14] *See, e.g.*, FEDERAL TRADE COMMISSION, BUREAU OF ECONOMICS REPORT, THE EFFECTS OF RESTRICTIONS ON ADVERTISING AND COMMERCIAL PRACTICE IN THE PROFESSIONS: THE CASE OF OPTOMETRY (1980) [hereinafter OPTOMETRY REPORT].

[15] *See, e.g.*, A DOSE OF COMPETITION, *supra* note 12, at Exec. Summary, p. 20 and C. 8, p. 16.

[16] *See, e.g.*, In re American Medical Ass'n, 94 FTC 701 (1979) (final opinion & order) (regarding restrictions on truthful and non-misleading advertising by member physicians); Response from FTC Staff to Ms. Katherine M. Carroll, Executive Director of the Medical Practitioner Review Panel in New Jersey, concerning one of the advertising regulations of the New Jersey Board of Medical Examiners (Sept. 7, 1993), *available at* http://www.ftc.gov/be/healthcare/docs/AF%203.PDF.

[17] *See* Texas Bd. of Chiropractic Examiners, C-3379 (consent order issued Apr. 21, 1992), 57 Fed. Reg. 20279 (May 12, 1992).

[18] *See, e.g.*, OPTOMETRY REPORT, *supra* note 14.

[19] The Workshop website, with links to panelist presentations, archived webcasts, transcripts, and other materials, is available at http://www.ftc.gov/bc/healthcare/hcd/index.shtm.

could make basic health care more accessible to consumers.[20] The FTC staff comments supported the goals of the regulation, but expressed concern that a proposed requirement that all limited service clinic advertising – and no other clinic advertising – be pre-screened and pre-approved, could deprive consumers of useful information about available care and act as a barrier to entry for new competitors.[21] Massachusetts adopted the FTC staff's suggestions in its final regulations.[22]

Discussion

As noted above, the legislature's initiative to accommodate the potentially pro-competitive development of retail clinics may be of substantial benefit to Illinois health care consumers. At the same time, several provisions in HB 5372 raise competition concerns. First, certain ambiguous provisions could be read in ways that harm health care competition and consumers. For example, the proposed statutory definition of retail health care facilities – read in conjunction with Illinois law regarding the corporate practice of medicine[23] – could be read to imply that the proposed clinic restrictions apply according to clinic ownership or affiliation, rather than the nature of the services provided or the licensed professionals providing them. If so, the restrictions could, individually or collectively, work as a substantial barrier to entry for retail clinics in Illinois, which could tend to restrict the supply of basic health care services or raise their prices.

Second, certain provisions appear to impose special and potentially burdensome restrictions on the operation of retail clinics and, in some cases, on contracting between retail clinics, health care consumers, and third-party payers. For example, the special restrictions on retail clinic advertising may work to prohibit or chill consumer access to truthful and non-misleading information about prices for basic medical services. Although false or misleading marketing information can harm health care competition and consumers, access to truthful and non-misleading information is important to consumers' effective participation in their health care and health care expenditures.

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[20] *See* Massachusetts Dept. Pub. Health, *Commonwealth to Propose Regulations for Limited Service Clinics: Rules May Promote Convenience, Greater Access to Care* (Jul. 17, 2007), *available at* http://www.mass.gov/?pageID=pressreleases&agId=Eeohhs2&prModName=dphpressrelease&prFile=070717_clinics.xml (quoting the Commissioner of Public Health, "[i]f approved, these proposed regulations will not only help make very basic medical care convenient, they could also expand access to health care to very vulnerable populations").

[21] FTC Staff Comment Before the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics, 2 (Sept. 27, 2007), *available at* http://www.ftc.gov/os/2007/10/v070015massclinic.pdf.

[22] Memorandum from Paul I. Dreyer to Commissioner John Auerbach and Members of the Public Health Council, re Request to Promulgate Amendments to 105 CMR 140.000 (Licensure of Clinics) Regarding Limited Services Clinics 8 (Dec. 12, 2007) (staff heeding advice of Federal Trade Commission).

[23] *See, e.g.*, People by Kerner v. United Medical Service, Inc., 362 Ill. 442, 454-55 (Ill. 1936) (Corporate practice of medicine barred by Medical Practice Act because only individuals can obtain license under Act); *cf.* Berlin v. Sarah Bush Lincoln Health Ctr., 179 Ill. 2d 1, 4 (Ill. 1997) (general restrictions of "corporate practice doctrine" inapplicable to licensed hospitals).

A. Statutory Construction and Potential Competition Concerns

Certain provisions of HB 5372 could be read in ways that would discourage the new health care competition promised by retail clinics. [24] First, it is unclear whether the contemplated statutory restrictions on a "retail health care facility" apply to certain types of health care services and professionals or certain types of clinic owners. On the one hand the Bill states, "'Retail health care facility' or 'facility' means any institution, place, or building, or any portion thereof, devoted to the maintenance and operation of facilities for the performance of health care services located within a retail store or pharmacy at a specific location."[25] To a lesser extent, the definition points to specific health care services by excluding, e.g., general anesthesia from the menu of retail clinic services as a matter of definition.[26] To the extent that the definition of a "retail health care facility" is supposed to identify particular health care services subject to the Bill's restrictions, independent of clinic ownership, those criteria could be clearer.

However, the Bill may restrict retail health care competition if interpreted to exempt, e.g., physician-owned or hospital-owned clinics located in retail settings from its substantive requirements.[27] Under HB 5372, "[h]ospitals . . . ambulatory treatment centers, . . . , and offices of physicians, advanced practice nurses, . . . , and physician assistants, as well as pharmacies that provide pharmaceutical services, are not to be construed to be retail health care facilities."[28] Traditional health care providers are entering the retail clinic market – as clinic owners, operators, or affiliates – often offering the same types of services as those offered by independent operators.[29] That trend could

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[24] An additional statutory ambiguity of potential significance is discussed with substantively related provisions below, at notes 58-60. Also potentially ambiguous is the requirement that each clinic "have on hand at all times an operator adequately trained in the correct operation of the facility." HB 5372 § 35. To the extent that this represents an additional requirement to that requiring the presence of licensed health care professionals "at the time the services are provided," it could be made clearer. *Id.* at § 25(a)(2). In addition, duplicating the more specific timing language of Section 25 may avoid any possible impression that "at all times" implies that on-site staffing is required around the clock, independent of whether the clinic or its larger retail home is open for business.

[25] HB 5372 § 10.

[26] *Id.* (excluding "surgical services or any form of general anesthesia," as a matter of definition, from the range of services provided by retail health care facilities, although we are unaware of retail or limited service clinics offering such services. *See generally supra* notes 3-6, and accompanying text, regarding features of retail clinics).

[27] *See, e.g.*, People by Kerner v. United Medical Service, Inc., 362 Ill. 442, 454-55 (Ill. 1936) (Corporate practice of medicine barred by Medical Practice Act because only individuals can obtain license under Act); *cf.* Berlin v. Sarah Bush Lincoln Health Ctr., 179 Ill. 2d 1, 4 (Ill. 1997) (general restrictions of "corporate practice doctrine" inapplicable to licensed hospitals).

[28] *Id.*

[29] *See, e.g.*, Mary Kate Scott, *Health Care In the Express Lane*, *supra* note 3, at 4-5 (regarding general services and facilities for retail clinics) and 7 (regarding clinics affiliated with large traditional providers, such as Aurora, AtlantiCare, Sutter, Geisinger, Memorial South Bend Indiana); *cf.* Milt Freundenheim, *Wal-Mart Will Expand In-Store Medical Clinics*, N.Y. Times, Feb. 7, 2008, *available at*

benefit consumers by improving competition on price or qualitative aspects of basic medical services. At the same time, imposing different regulatory burdens on retail clinics according to ownership or affiliation – independent of the particular health care services provided or the types of professionals providing them – could deter the entry of certain competitors into the retail clinic market in Illinois or raise their operating costs, which could, in turn, limit the supply of basic health care services or raise their prices. If there is no substantial basis for treating retail clinics differently based on the type of ownership, the regulatory imbalance may harm competition without any countervailing health or safety benefits for Illinois consumers.

Second, the requirement that "[a] physician may be a medical director of no more than 2 facilities,"[30] may be an undue and potentially costly limitation on the organization and operation of retail clinics. The substantive obligations of a medical director, who must be a licensed physician, appear to be limited to Sections 25 and 35 of HB 5372.[31] Section 25 requires a clinic's medical director to determine the limited set of medical services to be provided by the clinic.[32] Under Section 35, the medical director, and the licensed health care professionals who staff the clinic, must approve the clinic's operating protocols.[33]

The health or safety rationale for limiting physicians so that they can be involved in the design of protocols and procedures for only two clinic settings is unclear. It is possible that these institutional design roles might best be served by more specialized practice expertise than the two-clinic limit would permit. Moreover, the limitation could give large, incumbent institutional health care providers a competitive edge to the extent that such providers could leverage their existing physician staff to fill these limited, annual administrative roles.

At the same time, the two-clinic limit could be read to impose special supervisory requirements on licensed advanced practice nurses when those nurses provide limited health care services in a retail setting. The Bill requires advanced practice nurses to operate in accordance with a collaborative agreement under Section 65-35 of the Nursing Practice Act,[34] a requirement that appears to be redundant with the Nursing Practice Act itself. The Nursing Practice Act does not generally appear to restrict collaborative agreements so that a physician can only collaborate with some fixed small number of advanced practice nurses. Staff recognizes the importance of minimum licensing and

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http://www.nytimes.com/2008/02/07/business/07clinic.html?ref=business (regarding planned Wal-Mart affiliations with hospitals).

[30] HB 5372 at § 25(a)(4).

[31] *See id.* ("The facility must have a medical director who is a physician licensed to practice medicine in all its branches with active medical staff privileges to admit patients to a local licensed hospital.")

[32] *Id.* at § 25(a)(1) (scope of services "determined" by the medical director and "approved by the Department").

[33] *Id.* at § 35(4).

[34] *Id.* at § 25(a)(3).

practice standards for various categories of health care providers. Nonetheless, the basis for imposing special supervisory burdens in a retail setting – or perhaps in a retail setting according to clinic ownership – is not clear. Such special requirements could potentially restrict competition, as they might tend to suppress supply or raise prices without conveying countervailing benefits to Illinois health care consumers.

Third, HB 5372's "nondiscrimination" provision could potentially restrict payers from using different copayments, deductibles, or co-insurance requirements in structuring networks that include retail clinics.[35] The provision might be read to restrict the ability of third-party payers to negotiate favorable terms with retail clinics and to pass certain savings on to health care consumers via reduced copayments. Under the nondiscrimination provision, retail clinics "must be subject to the same co-payment, deductible, or co-insurance requirements that are required of an insured or enrollee in the case of services provided by a physician, advanced practice nurse, or physician assistant."[36] In effect, this might prohibit payers from using incentives, such as lower copayments, to encourage beneficiaries to use lower-cost providers for basic health care services, if the lower-cost providers are retail clinics. It could also prohibit payers from charging higher co-payments for retail clinic services if these services were found to increase the payers' costs relative to visits to alternative providers. Illinois has broad latitude to regulate the insurance industry within its borders and FTC staff does not intend to comment generally on the basic standards for health care coverage in Illinois. However, staff is concerned that this provision might ultimately reduce the benefits of competition that Illinois health care consumers would otherwise enjoy.

In health care services markets, differential payments, copayments, and deductible requirements are common across diverse payment and reimbursement arrangements employed by third-party payers, such as "preferred provider organizations."[37] Often, the promise of such differential payments is critical to the ability of third-party payers to negotiate discounted provider fees.[38] To undercut that ability would diminish the power of third-party payers to manage costs for covered services. That could, in turn, have a pernicious effect on the prices that consumers pay for such services – perhaps especially

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[35] HB 5372 § 50.

[36] *Id.* The provision does permit different copayments for in-patient and outpatient services, but the significance of this is unclear given the Bill's stipulation in § 10 that retail clinics "may not provide beds or other accommodations for either long-term or overnight stay of patients."

[37] *See generally* A DOSE OF COMPETITION, *supra* note 12, at Exec. Summ. 6-13. Such incentives also are broadly applied with regard to pharmacy benefits. *See* FEDERAL TRADE COMMISSION, PHARMACY BENEFIT MANAGERS: OWNERSHIP OF MAIL-ORDER PHARMACIES, 17-19 (Aug. 2005) ("PBM STUDY"), *available at* http://www.ftc.gov/reports/pharmbenefit05/050906pharmbenefitrpt.pdf (regarding, e.g., differential copayments for mail order pharmacies). *See also* FTC Staff Comment to the Hon. Nelie Pou Concerning New Jersey A.B. A-310 to Regulate Contractual Relationships Between Pharmacy Benefit Managers and Health Benefit Plans, 6-8 (Apr. 2007) (regarding pharmacy plan copayments and "any willing provider" requirements), *available at* http://www.ftc.gov/opp/advocacy_date.shtm; Letter from FTC staff to Patrick C. Lynch, Attorney General, and Juan M. Pichardo, Deputy Senate Majority Leader, State of Rhode Island and Providence Plantations, 4 (Apr. 8, 2004), *available at* http://www.ftc.gov/os/2004/04/ribills.pdf.

[38] A DOSE OF COMPETITION, *supra* note 12, at Exec. Summ. 12.

for those Illinois consumers for whom copayments and deductibles represent an increasing burden.[39] The Bill's "non-discrimination" provision would be problematic – for competition and consumers – if it were to restrict such incentives with regard to retail clinics. It could also prevent payers from negotiating favorable terms with retail clinics in the first place, if contracts could not be based on the volume of business that might be anticipated with discounted copayments. The rationale for prohibiting lower copayments or deductibles when consumers receive lower-cost basic medical care from licensed health care professionals, in the particular setting of a retail clinic, is unclear.[40]

Finally, the Bill's requirement that a retail clinic provide "separate restrooms" may increase costs for retail clinics.[41] If existing restrooms in the retail settings housing retail clinics satisfy this requirement, retail clinics can easily meet this requirement, so it is unlikely to have a substantial impact on costs. However, to the extent that "separate restrooms" is read generally to require new construction of restrooms within a clinic space, it may represent a significant additional sunk cost for new clinics.[42] In that case, the legislature should determine what benefits, if any, the restroom requirement has and weigh them against the requirement's additional costs.

B. Competition Concerns Raised by Special Clinic Requirements

1. Advertising Restrictions

Some of the advertising restrictions under HB 5372 may unduly restrict consumer access to truthful and non-misleading information about basic health care services. In particular, staff is concerned about the Bill's restrictions on advertising price information. Under HB 5372, it would be "unlawful for a facility to advertise comparisons of its fees for available services with the fees of other facilities with respect to which a permit has been issued under this Act or that are licensed or otherwise authorized to operate under

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[39] *See, e.g.* Reed Abelson and Milt Freudenheim, Even the Insured Feel the Strain of Health Costs, N.Y. Times, May 4, 2008, *available at* http://www.nytimes.com/2008/05/04/business/04insure.html?th&emc=th.

[40] A related concern is the Bill's restriction on a facility advertising that it "will accept as payment for services rendered . . . the amount the third party payor covers as payment in full." HB 5372 at at § 105(d). If the provision is intended as a special case of the Bill's Section 105(c) advertising restrictions, staff suggests that it be clarified as such. That is important because the provision could be read to prohibit truthful advertising of discounts for certain insured consumers if, for example, a clinic would waive a copayment otherwise required under a consumer's health benefit plan. Restricting such information could prove not just a competitive disadvantage for clinics having such prices to advertise, but a loss for Illinois health care consumers for whom insurance copyaments or deductibles are a significant burden. If there is a basis for restricting such advertising in certain limited circumstances -- if, for example, certain sorts of copayment advertisements prove to be misleading -- the Legislature should consider a provision more narrowly tailored to that basis and those circumstances.

[41] HB 5372 § 35(a)(3).

[42] It has been reported, for example, that clinics "are typically between 200 and 500 square feet" and that retailers have a "one-time cost of about $20,000 - $100,000 dollars to make the space 'broom ready," with average setup costs of about $50,000. Mary Kate Scott, *Health Care in the Express Lane*, *supra* note 3, at 4. In that context, new construction of separate restroom facilities could represent a significant barrier to entry for retail clinics.

any other Illinois law."[43] Fee comparisons are potentially objective, truthful, and non-misleading information of significant value to health care consumers and health care competition. Such information may be especially important for those Illinois consumers who may be uninsured, underinsured, or otherwise subject to limited access to basic medical care.

As the FTC staff has observed in other contexts, "The economics literature contains considerable evidence that the introduction of advertising into markets can have a positive effect on market performance, through lower prices, product improvements, or beneficial changes in consumer purchases."[44] Those benefits apply equally to the advertising of professional health care services.[45] The free flow of truthful advertising can be equally critical to both providers and consumers and might be especially important where emerging health care entities offer novel and more convenient access to care[46] or price advantages for marginal health care consumers.[47]

The Commission has the authority under the FTC Act to pursue false or misleading advertisements.[48] Illinois may also have an interest in the enforcement of general state law prohibitions against deceptive advertising.[49] It is important, however, that regulations aimed at protecting consumers from false or misleading information avoid unnecessarily impeding consumer access to truthful, non-misleading information about the range of available health care services.[50]

Consumers' interests in access to truthful and non-misleading information about goods and services in the market have been at the core of the Supreme Court's

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[43] HB 5372 at § 105(b).

[44] P. Ippolito & J. Pappalardo, *Advertising Nutrition & Health: Evidence from Food Advertising 1977-1997* E-20 (2002) (FTC Bureau of Economics Staff Report), *available at* *http://www.ftc.gov/opa/2002/10/advertisingfinal.pdf*.

[45] *See, e.g.*, Terry Calvani, James Langenfeld & Gordon Shuford, *Attorney Advertising and Competition at the Bar*, 41 VAND. L. REV. 761, 779-81 (1988) (surveying empirical evidence regarding advertising in health care professions as an example of advertising for professional services outside the legal environment).

[46] *See* Council on Medical Service Report (A-06), *supra* note 4, at 1.

[47] *Id.* at 1.

[48] *See, e.g.*, *supra* notes 8-10 (FTC authority and enforcement actions). The threat of enforcement acts, in conjunction with market forces, as a deterrent to the dissemination of false or misleading advertising.

[49] In addition, the state may have a basis for reinforcing general state law prohibitions against deceptive advertising (see 720 ILCS 295/1a (2008)) with sector-specific provisions, such as a prohibition of "false, fraudulent, deceptive, or misleading material" regarding retail clinic services. HB 5372 § 105(c).

[50] For that reason, FTC staff expressed concern that a proposed Massachusetts requirement that limited service clinic advertising be pre-screened and pre-approved, could deprive consumers of useful information about available care and act as a barrier to entry for new competitors. FTC Staff Comments, *supra* note 21, at 2.

commercial speech jurisprudence since *Virginia State Board of Pharmacy*.[51] If commercial speech is not false or misleading, and does not concern unlawful activities, restrictions on that speech must satisfy two conditions: they must serve a substantial government interest; and they may not be more extensive than necessary to serve that interest.[52] Illinois' interest in isolating its own consumers from objective and truthful price information is unclear. To the extent that evidence emerges that certain particular ways of framing price information are inherently misleading, FTC staff suggests that the state consider regulations more narrowly tailored to such types of statements.

2. Alcohol and Tobacco

The Bill's prohibition against locating a clinic "in any store or place that provides alcohol or tobacco products for sale to the public" may also limit competition.[53] FTC staff recognizes the state's interest in safeguarding the health and welfare of its citizens and the fact that such interests may prompt regulatory restrictions that guard against, for example, the sale of otherwise lawful alcohol and tobacco products to minors.[54] However, the rationale for not allowing a clinic in a retail store that also sells tobacco or alcohol is unclear. At the same time, this restriction could limit the supply of retail clinics and the basic medical services they would provide if retail stores were to decide sales of tobacco and alcohol were more profitable than having a retail health clinic. Or, the requirement could raise the retail clinic's costs[55] and increase prices for those services.

Further, there is no such general restriction that applies to other health care services, such as a prohibition on tobacco sales in doctors' buildings or free-standing pharmacies, or on the placement of pharmacies and pharmacy services in establishments such as grocery stores or big-box retailers that also sell tobacco products.[56] The rationale for restricting tobacco sales in proximity to one particular type of health care service provider is also unclear.

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[51] Virginia State Board of Pharmacy v. Virginia Citizens Consumer Council, 425 U.S. 748, 770 (1976) (state's interest in integrity of pharmacy profession does not justify unnecessary suppression of truthful advertising under First Amendment).

[52] Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n of N.Y., 447 U.S. 557, 564 (1980).

[53] HB 5372 § 45.

[54] FEDERAL TRADE COMMISSION, POSSIBLE ANTICOMPETITIVE BARRIERS TO E-COMMERCE: WINE, FTC Staff Report, 11-12 (July 2003), *available at* http://www.ftc.gov/os/2003/07/winereport2.pdf. Regarding Illinois law, see generally Illinois Liquor Control Act of 1934, § 235 ILCS 5 *et seq.* (2008) and Tobacco Products Tax Act of 1995, § 35 ILCS 143 *et seq.* (2008).

[55] For example, certain retail settings might demand different lease terms if forced to abandon alcohol or tobacco revenue to house retail clinics.

[56] *Cf., e.g.*, § 35 ILCS 130/4(c) (regarding persons ineligible for cigarette distributor's license); *id.* at § 143/10-20 (pesons ineligible for tobacco products licenses). Staff does note that sales of alcoholic liquor within 100 feet of a hospital are generally prohibited, albeit subject to certain restrictions, but that those restrictions do not appear to pertain more generally to providers of health care services. *See* § 235 ILCS 5/6-11 (sale near churches, schools, and hospitals).

Finally, to the extent that hospital-owned or physician-owned retail clinics might be exempted from the Bill's requirements independent of location or services provided, this provision could place significant restrictions on certain competitors but not others, within the same market. If so, the provision would be a further barrier to competition among providers of such basic medical services, to the potential detriment of Illinois health care consumers.

3. Facilities and Operating Requirements

There are several other provisions of the Bill that may impose special operating burdens on retail clinics. For example, each clinic "must have a designated receptionist and waiting area."[57] Certain retail health care clinics in other states appear to operate without the services of a separate receptionist and waiting area.[58] The requirement of a designated receptionist, separate from those licensed health care professionals providing care at the facility, could impose a significant additional operating cost on certain small clinics.[59] At the margin, such added costs could reduce the supply of basic medical services or increase the prices at which they are offered. At the same time, the requirement appears unrelated to any specific health concerns about the care such clinics would deliver.

Conclusions

The Commission staff recognizes that important health and safety concerns may be raised by the marketing or provision of health care services. At the same time, it appears that retail health care facilities have the potential to expand access to basic health care services. Illinois' initiative to provide for the emergence of this new model of health care delivery, within the bounds of responsible practice and professional licensing standards, is to be encouraged. However, several of HB 5372's provisions could harm health care competition – and the emergence of new clinics – without providing countervailing benefits for Illinois health care consumers.

Staff suggests the Legislature considering clarifying those provisions in the Bill that may be subject to interpretations that would limit health care competition so that they are not erroneously interpreted or applied in ways that unnecessarily put retail clinics at a competitive disadvantage to other providers of similar services. Second, as several of the Bill's provisions appear on their face to place undue regulatory burdens on retail clinics relative to other providers of the same or similar services, staff suggests that the Legislature consider eliminating such unequal treatment of retail clinics. If there is evidence that specific health, safety, or other risks to consumers are associated with particular features of retail clinics in providing services, staff suggests that remedial regulations be narrowly tailored to address those risks in as competitively neutral a

[57] HB 5372 § 35(a)(5).

[58] Many employ, for example, electronic check-in at kiosks or check-in terminals. *See, e.g.*, Vimo Research Group, *Retail Health Care Clinics Overview and Atlas* 9 (Sept. 2007).

[59] *See supra* notes 3-6, 41-2, and accompanying text.

manner as is feasible. Absent these suggested changes, HB 5372 could substantially limit the potential benefit of retail clinics to Illinois health care consumers, especially those with inadequate access to basic medical services, by making it more difficult to open and operate such clinics, or by raising their costs of doing so, which likely would raise the costs of their services to consumers.

Respectfully submitted,

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