Submission of the United States
October 2004 OECD Roundtable on Competition in the Health Professions

Questions about the role of competition and market-oriented strategies in the health care sector are of vital importance as countries seek to meet the challenges of rising health care costs, promoting high-quality, affordable health care, and ensuring access to care. The United States competition enforcement agencies – the Federal Trade Commission and the Antitrust Division of the Department of Justice ("the Agencies") – have been actively involved in examining health care markets for nearly three decades. Our function is not to regulate these markets, but rather to eliminate barriers to competition that prevent markets from functioning as effectively as possible.

Our response to the issues raised in the Secretariat's paper concerning competition in the health professions begins with an overview of the perspective that underlies the Agencies' activities in the health care sector. We then discuss agency actions relating to some specific issues regarding health care professionals that are the focus of the Roundtable. Following the framework outlined in the Secretariat's paper, we address first some activities relating to "structural issues" (entry standards, scope of practice definitions, and regulation of the organizational structure of professional firms), and second the "behavioral issues" (advertising, fee setting, and contractual relationships with payers). As requested, we give special attention to those health care professions in which third party payment has played a less prominent role than in medical services, in particular dental and vision care services and products.

In addition, attachments to this report provide: (1) a list of Agency reports relating to health care; (2) a list of competition advocacy activities in health care; and (3) a guide to Agency materials concerning antitrust law in health care available at the Federal Trade Commission and Department of Justice web sites.

Overview

It has been almost 30 years since the beginning of active antitrust enforcement in U.S. health care markets. Nonetheless, there is still ongoing debate about whether and how competition policy applies to health care and its potential as a tool for improving the U.S. health care system. Thus, in various settings – whether litigation, competition advocacy, or guidance to the public – there continues to be a need to address fundamental issues about the role of competition and antitrust enforcement in health care. These are some recurring themes that the Agencies articulate:

- *Competition has an important role in health care notwithstanding the special characteristics of these markets.* Promoting competition does not mean ignoring the special characteristics of health care markets or assuming that the market, if left alone, will cure all problems. Factors such as information disparities, third party payment, the prevalence of regulation (including self-regulation), and the need to ensure access for the poor, present challenges to the use of competitive strategies. But governments and private parties can play an important role in creating conditions and incentives for effective competition.

- *There is no need for special antitrust rules for health care*. Antitrust law and analysis is sufficiently flexible to take into account the special characteristics of these markets

- *Self-regulation has an important role to play in promoting competition*. Private professional association efforts to provide information to consumers and to prevent deceptive advertising, or other abuses that distort the ability of market forces to reflect consumer preferences, can benefit competition

- *Competition is an important tool for stimulating innovative strategies to control costs, increase quality, and provide consumer choice*. The difficult task of improving quality and ensuring cost-effective care requires creativity and experimentation by market participants. It is critically important to address government regulations and private arrangements that unnecessarily impede the incentive or ability of market participants to pursue such innovation.

- *Antitrust enforcement plays a key role in ensuring that innovations by governments and private actors are able to compete for acceptance in the marketplace*. Antitrust in the health care sector has helped assure that new and potentially more efficient ways of delivering and financing health care services can arise and compete in the market for acceptance by consumers. Although health care markets have changed dramatically over time, and continue to evolve, collective action by health care providers to obstruct new models for providing or paying for care, or to interfere with cost-conscious purchasing, remains a significant threat to consumers.

- *Antitrust does not pick winners and losers*. Many cases have focused on health care providers' efforts to obstruct new approaches to delivery, financing, or paying for care, but the Agencies do not favor any particular model of health care delivery, or type of provider, over another. The goal is simply to deter restraints that unduly limit the options available in the market or artificially raise prices, so that consumers will be free to choose the health care arrangements they prefer at competitive prices.

Many of the matters in the discussion that follows reflect these themes, in particular the use of antitrust to address competitors' efforts to resist innovations in delivering or paying for care, and the importance of distinguishing anticompetitive from procompetitive self-regulation.

Structural Issues – Entry, Scope of Practice, and Organizational Structures

In the United States, government regulation of health care professionals occurs primarily through state governments. State laws set standards for licensure, define the scope of practice of the profession, and regulate various types of business and professional behavior. These regulatory schemes are carried out through state licensing boards. The boards are typically composed predominantly of members of the regulated profession.

Principles of federalism limit the application of the federal antitrust laws to state-imposed restraints on competition. In essence, the "state action doctrine" means that states can decide to displace competition with regulation as long as the state legislature clearly expresses its intent to do so, and state officials actively supervise private conduct taken pursuant to state policy.

Actions by state professional licensing boards are sometimes, but not always, exempt from antitrust enforcement by virtue of the state action doctrine. A current Federal Trade Commission case involves restraints on practice by dental hygienists imposed by a state board of dentistry.[1] The nine-member South Carolina State Board of Dentistry includes seven dentists, six of whom are elected by the dentists in their local area.

The Federal Trade Commission complaint alleges that the Board illegally restricted the ability of dental hygienists to provide preventive dental services (cleanings, fluoride, and sealants) in school settings. The state legislature in 2000 eliminated a statutory requirement that a dentist examine each child before a hygienist may perform preventive care in schools, in order to address concerns that many schoolchildren, particularly those in low income families, were receiving no preventive dental services. In 2001, the complaint states, the Board re-imposed the dentist examination requirement. The complaint charges that the Board's action unreasonably restrained competition in the provision of preventive dental care services, deprived thousands of economically disadvantaged schoolchildren of needed dental care, and that its harmful effects on competition and consumers could not be justified. The Board sought to have the complaint dismissed on the ground that its actions are exempt from the antitrust laws by virtue of the state action doctrine. The Commission denied the motion to dismiss, and the Board is seeking an interlocutory review of that ruling by a federal appellate court.

Concerns about the potential for overly restrictive regulation by state licensing boards composed of members with a stake in competitive conditions in the regulated market are longstanding. Years ago many states responded by adding a public member to such boards. As part of recent series of hearings addressing a broad range of issues relating to competition and health care, the Agencies received testimony concerning restraints on allied health providers. In its report on the hearings, the Agencies recommend that states consider a proposal for restructuring licensing boards advocated by the Institute of Medicine (a private advisory body), which undertook an extensive, congressionally-mandated study of the role of allied health professionals.[2] This proposal would have at least half of the members of state licensing boards chosen from outside the regulated profession, and these individuals would include experts in fields such as health services research, economics, and consumer affairs.

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[1]*South Carolina State Board of Dentistry*, FTC Docket No. 9311 (complaint issued September 17, 2003) (http://www.ftc.gov/os/adjpro/d9311/index.htm).

[2]*Improving Health Care: A Dose of Competition: A Report by the Federal Trade Commission and the Department of Justice* (July 2004), Chapter 2 at 30 (http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf).

The Federal Trade Commission has long had an active program of competition advocacy regarding regulations in the health professions. These activities have included recommendations concerning restrictions on practice by various allied health professionals, including dental hygienists, opticians, and nurse-midwives.[3]

Changes in technology have also raised new issues regarding the application of state licensure requirements. The Federal Trade Commission recently issued a staff report concerning competition from sales of replacement contact lenses over the Internet.[4] The staff recommended that states not require that an Internet seller have a professional license to sell replacement contact lenses, and, if further regulation is deemed necessary, states should consider adopting simple registration requirements. The use of contact lenses raises significant health issues, but the report concludes that requiring a professional license to sell replacement contact lenses over the Internet is likely to raise prices and reduce convenience to consumers, without substantially increasing health protections already provided by existing prescription requirements and general consumer protection laws.

With respect to limits on the organizational structures that health professionals may adopt, such restraints have arisen both in state regulation and in private association codes of ethics. These include bans on: employment by a "lay"corporation; partnerships with allied health providers; use of branch offices or trade names; and salaried employment. The Federal Trade Commission has undertaken extensive study of such "commercial practice" restraints in optometry. After an empirical study comparing states with different regulatory schemes, it found that restrictions on the commercial practice of optometry increased prices but did not improve

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[3] *See, e.g.*, Federal Trade Commission Staff Comments to the South Carolina Legislative Audit Council (concerning dental hygienists and optometrists) (January 11, 1993); Statement from Federal Trade Commission Staff to the Joint Administrative Rule Review Committee of the Washington State Legislature (concerning opticians) (December 15, 1992); Federal Trade Commission Staff Comments to the California Board of Dental Examiners (concerning dental hygienists) (February 1988); Comments of Federal Trade Commission Staff to the Council of the District of Columbia (concerning expanded role nurses) (November 22, 1985).

[4] *Possible Anticompetitive Barriers to E-Commerce: Contact Lenses: A Report from the Staff of the Federal Trade Commission* (2004) (http://www.ftc.gov/os/2004/03/040329clreportfinal.pdf). In 2003, the U.S. Congress enacted the Fairness to Contact Lens Consumers Act, 15 U.S.C. 7601-7610, which requires prescribers of contacts lenses to provide patients with a copy of their contact lens prescription upon completion of a contact lens fitting. The Federal Trade Commission Rule implementing the Act is set forth at 16 C.F.R. Part 315 (http://ecfr.gpoaccess.gov/cgi/t/text/text-idx?c=ecfr&sid=3ad5b48a02eb1707974872e00175bbb5&rgn=div5&view=text&node=16:1.0.1.3.39&idno=16).

the quality of professional services available in the market.[5] In addition to advocating the relaxation of state-imposed restraints,[6] the Commission has taken enforcement action against private optometric association rules limiting organizational structures.[7]

Behavioral Issues

Advertising

The importance of advertising to competition is well-understood. Advertising can provide consumers with information about who is selling what, at what prices, and under what conditions. Both theory and empirical evidence link the presence of advertising in the health professions with lower prices. Advertising also can play a role in encouraging innovation and entry in health care markets.

Broad state-imposed bans on advertising by health care professionals have been essentially eliminated as a result of the evolution of constitutional protections accorded to "commercial speech." At the same time, antitrust law enforcement successfully attacked private professional association bans, beginning with the Federal Trade Commission's complaints against the American Dental Association and the American Medical Association in the mid-1970s.[8] The Federal Trade Commission also brought enforcement actions to eliminate various advertising restraints imposed by state licensing boards in the health professions. For example, the Commission challenged prohibitions imposed by state boards of dentistry and optometry on

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[5]Bureau of Economics, Federal Trade Commission, *Effects of Restrictions of Advertising and Commercial Practice in the Professions: The Case of Optometry* (1980).

[6]*See, e.g.,* Comments by Federal Trade Commission to The Honorable Ward Crutchfield, Tennessee Senate Majority Leader (concerning Senate Bill 855, which would amend the portion of the Tennessee Code regulating the practice of Optometry) (April 29, 2003) (http://www.ftc.gov/be/v030009.htm); Comments of the Staff of the Federal Trade Commission to The Honorable Gary A. Merritt, Kansas House of Representatives (concerning a bill to clarify the conditions under which optometrists and non-optometrists could enter into lease agreements) (February 10, 1995) (http://www.ftc.gov/be/v950004.htm).

[7]*Oklahoma Optometric Ass'n*, 106 F.T.C. 556 (1985) (consent order); *Michigan Optometric Ass'n,* 106 F.T.C. 342 (1985) (consent order).

[8]*American Dental Ass'n*, 94 F.T.C. 403 (1979)(consent order), order modified, 100 F.T.C. 448 (1982) and 101 F.T.C. 34 (1983); *American Medical Ass'n*, 94 F.T.C. 701 (1979), aff'd as modified, 638 F.2d 443 (2d Cir. 1980), aff'd by an equally divided Court, 4555 U.S. 676 (1982).

advertising discounted prices, as well as an optometry board's restraints on advertising of affiliations between optometrists and retail optical stores.[9]

With the success in eliminating broad advertising bans, the primary issues in the realm of advertising restraints now focus on distinguishing between appropriate regulation to prevent false or misleading advertising and unreasonably broad suppression of advertising cast in the form of rules against deception. Because deceptive advertising distorts the operation of market forces, it has long been recognized that regulation of deceptive advertising can serve to promote competition. The Commission's orders barring professional associations from restricting advertising consistently provide that the association may adopt and enforce reasonable rules to prevent advertising that is false or misleading.

But the risk remains that professional societies will take an overly broad view of what is deceptive. The Federal Trade Commission's case against the California Dental Association illustrates this concern and demonstrates the continuing challenges that enforcers can face in this area.[10] The case involved bans on various forms of price and non-price advertising. For example, while advertising of specific prices for particular services was permitted, the Association – in the name of preventing potential deception – required extensive disclosures in any offer of discounted prices. These requirements served to preclude offers of across-the-board fee discounts, such as the type of senior citizen discounts that are commonly used outside the professions. The Association also banned other types of representations about price, including statements such as "reasonable fees" or "ask about our low prices," statements that may be especially important when dentists advertise in telephone directories or other media where advertising of specific prices is not possible.

Although the court of appeals agreed with the Commission that the Association's suppression of various categories of price and non-price advertising was not justified on grounds of deception, a narrowly divided Supreme Court was unwilling to sustain the Commission's decision. In reaching its conclusion, the majority placed great emphasis on information disparities in professional services markets. As a result, it held that a more thorough inquiry into the effects of the Association's restraints was required before reaching a conclusion that those restraints were anticompetitive.

It is, of course, critically important to prevent deceptive advertising by health professionals. The Federal Trade Commission, under its consumer protection authority, plays a

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[9]*Louisiana State Board of Dentistry*, 106 F.T.C. 65 (1985)(consent order); *Massachusetts Board of Registration in Optometry*, 110 F.T.C. 549 (1988).

[10]*California Dental Ass'n*, 121 F.T.C. 190 (1996), *aff'd,* 128 F.3d 720 (9th Cir 1997), *vacated and remanded*, 526 U.S. 726 (1999), *rev'd and remanded*, 224 F.3d 922 (9th Cir. 2000).

role in attacking deceptive advertising in the health professions. Its most recent cases concerned misleading claims about the results of laser eye surgery.[11]

Fee Setting

The antitrust laws' prohibitions on price fixing bar professional associations from adopting fee schedules, recommending fees, or negotiating fees on behalf of their members. The Agencies vigorously pursue price fixing violations, and in some circumstance such conduct by professionals has prompted criminal prosecution by the Department of Justice.[12] At the same time, legitimate concerns about the needs of providers, consumers, and payers for information can be addressed in ways that do not involve price fixing. With appropriate safeguards, professional associations can undertake various activities to provide information about prices to members, consumers, and third party payers, and can also take disciplinary actions against abusive behavior by their members.

Professional associations can conduct and disseminate fee surveys, subject to certain safeguards to avoid the risk of collusive pricing or collective bargaining. Statement 6 of the Agencies' *Statements of Antitrust Enforcement Policy in Health Care* describes conditions – for example, that the data be at least 3 months old and there be at least 5 providers reporting data – that the Agencies believe make it unlikely that the survey would facilitate collusion.[13] It also sets forth the analytical approach that the Agencies use in assessing fee surveys that do not meet these criteria, and cautions against providers' exchange of future price information. The Agencies have also issued advice letters analyzing specific fee survey proposals by health care professionals.[14]

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[11] *The Laser Vision Institute,* FTC Dkt. No. C-4084 (July 8, 2003) (consent order) (http://www.ftc.gov/os/caselist/0223053.htm); *LCA-Vision, Inc, d/b/a/ LasikPlus*, FTC Dkt. No. C-4083 (July 8, 2003)(consent order) (http://www.ftc.gov/os/caselist/0223098.htm).

[12] *See, e.g., United States v. Lake Country Optometric Society*, W-95-CR-114 (W.D. Tex.1995) (agreement to raise prices for eye examinations) (http://www.usdoj.gov/atr/cases/f0600/0607.htm).

[13] *Statements of Antitrust Enforcement Policy in Health Care* (1996) (http://www.ftc.gov/reports/hlth3s.htm). The Statements are intended to explain the Agencies' analysis of several common types of collaborative activity among health care providers. The Statements provide some clear rules of thumb, including "antitrust safety zones" for certain types of arrangements, as well as a description of how the Agencies analyze conduct that does not fall within a safety zone.

[14]*See, e.g.,* Letter from Jeffrey W. Brennan, Federal Trade Commission, to Greg Binford (re PriMed Physicians) (Feb. 6, 2003) (http://www.ftc.gov/bc/adops/030206dayton.htm); Letter from Charles A. James, Department of Justice, to Jerry B. Edmonds (re Washington State Medical Association) (Sept. 23, 2002) (http://www.usdoj.gov/atr/public/busreview/200260.htm).

The *Statements of Antitrust Enforcement Policy in Health Care* also contain guidance regarding the collective provision of fee-related information to purchasers. As Statement 5 explains, the Agencies seek to distinguish potentially procompetitive activities to provide information to payers, including current or prospective fee information, from conduct that may reflect or facilitate unlawful agreements on price or other terms of dealing with purchasers.

Professional associations can also set up informational programs to assist patients through advisory peer review of fees, provided they take precautions to guard against the risk of a fee review program becoming a vehicle for coordinating fees or other anticompetitive conduct. As has often been noted, patients frequently lack good information about the prices of health care services, as well as about the quality and necessity of the services they receive.[15] Advisory peer review can provide information about the basis for a fee and an informed opinion about its reasonableness, and help patients decide whether to pay a disputed bill or to continue to patronize a particular provider. In an advisory opinion to the American Medical Association, the Federal Trade Commission approved a proposed professional society peer review of physicians' fees in which local societies would render opinions on patients' complaints about fees.[16] The Commission explained that the program contained a variety of safeguards to protect against the risk that the program would amount to professional society sanctioning of fee levels or have other anticompetitive effects. For example, opinions about fees charged would be not be binding on the physicians, the societies would impose no form of penalty on physicians for failure to adhere to the committees' advice as to the fee; the committees would not develop a benchmark schedule of fees; proceedings would be confidential; and the committee's opinions on the reasonableness of fees would not be publicized.

The AMA proposal also sought to establish a program to discipline members for charging unusually high fees. In cases where the fee charged arose from fraud, misrepresentation, undue influence, or other abusive behavior by the provider, professional discipline may improve the functioning of the market by deterring such behavior. Thus, the Commission found no antitrust problem in discipline based on such abuses. But the Commission warned that professional society discipline based on fee levels alone without regard to abusive conduct would amount to competitor regulation of fee levels. As such, it would pose inherent dangers to consumers.

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[15]Patients may receive care without any prior discussion with the provider of the price to be charged. Lack of information, the presence of third-party payment, and patients' reliance on their providers to act in the patient's best interests may all mean that patients often may not know what price will be charged until after the services are rendered. Consequently, patients may desire assistance in assessing the reasonableness of the price charged.

[16] Letter from Donald Clark, Secretary, Federal Trade Commission, to Kirk B. Johnson, American Medical Association, (February 14, 1994) (http://www.ftc.gov/bc/adops/009.htm).

Contractual Arrangements Between Providers and Payers

It is widely recognized that third party payment in health care can distort the incentives of providers and consumers. Various attempts have been made to devise alternatives to address these concerns. One approach was capitation arrangements in which primary care providers receive a fixed payment per patient per month from a health plan to provide all needed services. As health care markets have evolved, use of capitation has declined. Substantial efforts are currently being made to develop new ways to structure payment systems to improve incentives for providers to deliver high quality, cost-effective care and likewise to enhance incentives and information for consumers to choose providers that offer such care. For example, some large employers are experimenting with what are sometimes referred to as "pay for performance" arrangements, in which providers receive bonuses for meeting specified quality measures.

Such approaches depend on the availability of good measures of quality. Much attention is being given to ways to develop information systems and quality measurements that would allow more informed decision-making about quality.

The Agencies have expressed strong support for experimentation by both public and private payers in redesigning payment methods to better align incentives for quality and cost-effectiveness. Antitrust law enforcement has an important role to play in ensuring that such innovation is not stifled through collective resistance by providers. The Agencies have a long history of challenging anticompetitive collective bargaining with health plans – both private and government payers – by groups of competing health professionals, and this continues to be area of substantial enforcement activity.[17]

Some of the joint bargaining cases involve straightforward cartel behavior. In other situations, a group may offer some potential efficiencies. As in other industries, we look closely at whether the arrangement imposes anticompetitive restraints that go beyond what is necessary to produce those efficiencies. In addition, health care providers continue to raise arguments about disparities in bargaining power in contracting with health plans as a justification for agreements that create market power on the provider side. There is no reason, however, to expect that creating countervailing power would benefit consumers. Rather, our experience is that collective bargaining by providers raises prices without assuring quality. The Agencies instead emphasize effective antitrust enforcement regarding both buyers and sellers of health care services.

Another category of enforcement activity relating to contracts between providers and payers involves the use of "most favored nations" clauses. These provisions require the provider to give that payer at least the lowest price that it offers to any other customer. In some settings, such clauses can injure competition among providers and also among health plans. The

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[17]Descriptions of these enforcement actions can be found at http://www.ftc.gov/bc/healthindex.htm and http://www.usdoj.gov/atr/public/health_care/health_care.htm.

Agencies have challenged the use of an MFN by provider-controlled health plans in dentistry and pharmacy, charging that they were mechanisms by which competing providers sought to discourage discounting and maintain prices.[18] In addition, the Department of Justice has brought cases against health plans that were not provider-controlled, alleging that they were used by entities with market power to limit competition from other health plans.[19]

Competition advocacy involving provider-payer contracting has also included opposition to “any willing provider” laws. Such laws require a health plan to include in its network any provider that is willing to accept the terms set by the plan for participation. The Federal Trade Commission staff has filed comments on legislative proposals to adopt any willing provider provisions, noting that such requirements can reduce incentives for providers to offer discounted fees to health plans, and also may impede efforts to design health plans that offer consumers varying degrees of choice among providers. The comments have also pointed to empirical evidence that any willing provider laws raise health care costs.[20]

Conclusion

Health care markets continue to undergo tremendous change. The Agencies seek to protect competition so that new ways of delivering and financing health care services can compete for acceptance. We tailor our analysis and our enforcement strategies to the changing realties of those markets. As always, our enforcement efforts are directed to stopping activities that harm consumers, while seeking to provide market participants with the understanding they need to avoid antitrust pitfalls as they respond to market challenges.

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[18] *RxCare of Tennessee, Inc.*, 121 F.T.C. 762 (1996); *United States v. Delta Dental Plan of Arizona*, 1995-1 Trade Cas. (CCH) P 71,048 (D.Ariz. 1995).

[19] *United States v. Medical Mutual of Ohio*, 1999-1 Trade Cas. (CCH) ¶ 72,465 (N.D. Ohio 1999); *United States v. Delta Dental of Rhode Island*, 943 F. Supp. 172 (D. R. I. 1996); *United States v. Vision Service Plan*, 1996-1 Trade Cas, (CCH) ¶ 71,404 (D.D.C. 1996); *United States v. Oregon Dental Service*, 1995-2 Trade Cas. (CCH) ¶ 71,062 (N.D. Cal. 1995).

[20] *See, e.g.*, Comments of the Staff of the Federal Trade Commission to The Honorable Patrick C. Lynch, Attorney General, and The Honorable Juan M. Pichardo, Deputy Majority Leader, Senate, State of Rhode Island and Providence Plantations (concerning the competitive effects of bills containing "freedom of choice" and "any willing provider" provisions) (April 8, 2004) (http://www.ftc.gov/os/2004/04/ribills.pdf).