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FEDERAL TRADE COMMISSION
WASHINGTON, D. C. 20580

BUREAU OF
CONSUMER PROTECTION

August 21, 1984

COMMISSION APPROVED

Mr. Richard Morrison
Department of Health Regulatory Boards
Commonwealth of Virginia
517 West Grace Street
P.O. Box 27708
Richmond, VA 23261

Dear Mr. Morrison:

The Federal Trade Commission's Bureaus of Consumer Protection, Economics and Competition[1] are pleased to respond to your invitation to assist you in your regulatory review of the Virginia State Boards of Dentistry and Medicine, and to provide comments concerning the effects of various restrictions on health professionals.[2] In these comments we address the following points: (1) restrictions on advertising by dentists and physicians, (2) restrictions on the business practices of these professionals, including corporate employment, commercial locations, and trade name practice and (3) restrictions on the formation and operation of prepaid dental plans.

The Federal Trade Commission seeks to promote the national policy of encouraging competition among members of licensed professions to the maximum extent compatible with other legitimate state and federal goals. For several years, the Commission has been investigating the effects of restrictions on the business practices of professionals, including optometrists, dentists, lawyers, physicians and others. Our goal is to identify and seek the removal of such restrictions that impede competition, increase costs and harm consumers without providing countervailing benefits. The Commission has also been investigating the effects of other restrictions affecting health care delivery and has sought to identify restrictions that may limit competition and harm consumers without providing

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[1] These comments represent the views of the Bureaus of Consumer Protection, Economics and Competition of the Federal Trade Commission and do not necessarily represent the views of the Federal Trade Commission or any individual Commissioner. The Federal Trade Commission, however, has reviewed these comments and has voted to authorize their presentation.

[2] We have found no similar restrictions in the regulations of the Virginia Boards of Pharmacy or Nursing, also currently being reviewed by your Department.

countervailing benefits. In offering these comments, we acknowledge that we are not in a position to offer advice on what minimum level of quality of care the states should require.

For some time, the Commission has been concerned about public and private restrictions which limit the ability of professionals to engage in nondeceptive advertising.[3] Studies have shown that prices for professional goods and services are lower where advertising exists than where it is prohibited.[4] Studies have also shown that while advertising leads to lower prices it does not lead to lower quality services.[5] Therefore, to the extent that nondeceptive advertising is restricted, higher prices and a decrease in consumer welfare may well result. For this reason, we believe that only false and deceptive advertising should be prohibited. Any other standard is likely to suppress the dissemination of potentially useful information and may well contribute to an increase in prices.

Several provisions of Virginia law appear to ban the dissemination of nondeceptive information. Va. Code §54-187(7) (1982) bans advertising claims of superiority by dentists and §54-317(3) bans claims of superiority by physicians. These provisions would appear to prohibit at least some nondeceptive claims and therefore, at the appropriate time, you may wish to consider recommending any appropriate statutory revision. In addition, we would urge you to interpret these provisions to avoid prohibiting nondeceptive advertising to the extent possible. Some of the dental regulations which we discuss below -- -- for example, the provisions prohibiting all quality claims --

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[3] See, e.g., In re American Medical Association, 94 F.T.C. 701 (1978), aff'd, 638 F.2d. 443 (2d Cir. 1980), aff'd mem. by an equally divided court, 455 U.S. 676 (1982).

[4] Bureau of Economics, Federal Trade Commission, Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (1980) (discussed at page 9 below); Benham and Benham, Regulating through the Professions: A Perspective on Information Control, 18 J. L. & Econ. 421 (1975); Benham, The Effects of Advertising on the Price of Eyeglasses, 15 J. L. & Econ. 337 (1972).

[5] Bureau of Economics, Federal Trade Commission, Effects of Restrictions on Advertising and Commercial Practice in the Professions: The Case of Optometry (1980) (discussed at page 9 below); J. Cady, Restricted Advertising and Competition: The Case of Retail Drugs (1976); McChesney & Muris, The Effects of Advertising on the Quality of Legal Services, 65 A.B.A.J. 1503 (1979); Muris & McChesney, Advertising and the Price and Quality of Legal Services: The Case for Legal Clinics, 1979 Am. B. Found. Research J. 179 (1979).

appear to go beyond what is necessarily prohibited by the statute.

Board of Dentistry Rule 7.A.4.a. bans advertising of any statistical data or other information relating to past performance which could be interpreted as a representation of superiority or quality. Quality information, as well as price and availability information, is important to consumers because consumers ordinarily seek lower prices for a given level of quality and higher quality for a given price. Nondeceptive statistical data or other data on past performance may be particularly valuable in assessing quality because they provide consumers with objective, factual information. Of course, incomplete data that mislead consumers into believing that past results are more favorable than they really are could be banned as deceptive.

Rule 7.A.4.c. also bans representations regarding quality, including implications of quality and statements of opinion. This section might be interpreted to prohibit the dissemination of much truthful information, including statements about a practitioner's office equipment, personnel or techniques. Truthful claims about a practitioner's background, training or experience, which may be very useful to consumers in choosing a practitioner, may also be banned by this rule. Statements of opinion, which could also be nondeceptive in many cases, are also banned.

Rule 7.A.2.d. prohibits advertising which states or implies that a dentist is a certified or recognized specialist other than as permitted by the American Dental Association (ADA). We are concerned that this Rule may be broadly interpreted to prohibit, for example, advertising of denture services as implying that the practitioner is a specialist in the area of prosthodontics, or advertising of root canals as implying that the practitioner is a specialist in the area of endodontics, thus effectively prohibiting dentists from advertising many of the services they routinely perform.

Rule 7.A.2.f. requires disclosure of the original price whenever a discount is advertised. This has been interpreted in Policy Statement #14 to prohibit advertising which states "call and ask about our family, student and senior citizen discounts." Since it is impractical to state in an advertisement the regular prices of all the hundreds of services a dentist provides, this rule implicitly bans all advertising of discounts unless only a few specific services are advertised. Thus, this rule would prohibit dissemination of coupons entitling the bearer to a percentage discount on all of a dentist's services, as well as advertising of discounts on all services to certain groups. Truthful discount price advertising such as these examples would likely be particularly useful to consumers. We are aware of no evidence that such advertising is inherently misleading to consumers.

Rule 7.A.4.d., which prohibits "showmanship, puffery," "slogans," and so on, in effect prohibits dentists from using nondeceptive advertising and marketing techniques commonly used by other providers of goods and services. These techniques are used by advertisers to attract and hold consumers' attention; they help to communicate the message more effectively to consumers. Such techniques do not appear to be inherently deceptive and prohibiting them may well decrease the effectiveness of advertising, resulting in higher costs and possibly less frequent advertising. In addition, the vagueness of this provision may chill nondeceptive advertising in general.

The statutes and regulations governing dentists and several statutory provisions governing physicians also contain provisions that prohibit certain forms of commercial practice. The Virginia Code prohibits employment of dentists by lay corporations and bans associations and partnerships between dentists and other persons for the performance of dental services.[6] These restrictions prohibit, for example, partnerships between dentists and physicians or other professionals who might provide complementary health care services in a single office, as well as associations between dentists and lay persons or business corporations. Such restrictions, which limit the availability of equity capital for professional practices, may well increase the cost of capital to professional firms and hinder the development of high-volume practices that may be able to reduce costs through economies of scale.

The Virginia Code also prohibits both dentists[7] and physicians[8] from practicing their professions as lessees of any commercial or mercantile establishment. These provisions prevent physicians and dentists from locating their offices inside commercial establishments such as drug or department stores, where they can establish and maintain a high volume of patients because of the convenience of such locations and because of a high level of "walk-in" patients. This higher volume may, in turn, allow professional firms to realize economies of scale which can be passed on to consumers in the form of lower prices. Restrictions on leasing from commercial establishments may, therefore, hinder the development of such high-volume, lower-priced practices.

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6 Va. Code §54-146, §54-183 (1982). Dentists even appear to be prohibited from hiring lay persons to manage their dental businesses. Va. Code §54-146 (1982). This appears to be an unnecessary restriction on the ability of dentists to hire persons with business expertise to handle the non-professional aspect of a dental office.

7 Va. Code §54-147.1 (1982).

8 Va. Code §54-278.1 (1982).

Virginia law also prohibits dentists[9] from practicing under a trade name. Trade names can be virtually essential to the establishment of large group practices and chain operations which can offer lower prices. Trade names are chosen because they are easy to remember and because they can convey useful information such as the location or other characteristics of a practice. Over time, a trade name can also come to be associated with a certain level of quality, service and price, thus facilitating consumer search. Without trade names, larger practices must use lengthy and difficult-to-remember names that include the individual names of all the practitioners or owners of a practice, and that communicate less information, as currently required by Virginia law.[10] The name of the practice also has to be changed periodically as members join or leave the firm, contributing to consumer confusion. Thus, without convenient and enduring trade names, development of high-volume, low-price practices becomes more difficult.

Restrictions such as these on the business practices of professionals can reduce competition in health care markets by preventing the formation and development of innovative forms of professional practice that may be more efficient, provide comparable quality, and offer competition to traditional providers. For example, in a case challenging various ethical code provisions enforced by the American Medical Association (AMA), the Commission found that AMA rules prohibiting physicians from working on a salaried basis for a hospital or other lay institution and from entering into partnerships or similar relationships with non-physicians unreasonably restrained competition and thereby violated the antitrust laws.[11] The Commission concluded that the AMA's prohibitions kept physicians from adopting more economically efficient business formats and that, in particular, these restrictions precluded competition by organizations not directly and completely under the control of physicians. The Commission also found that there were no countervailing procompetitive justifications for these restrictions.

Proponents of such restrictions claim that they are necessary to maintain a high level of quality in the professional services market. For example, they claim that employee-employer and other relationships between professionals and non-

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9 Va. Code §54-184 (1982). Va. Code §54-317 (1982) prohibits physicians from practicing under a false or assumed name. Many states interpret such language to prohibit trade name usage.

10 Va. Code §54-184 (1982).

11 In re American Medical Association, 94 F.T.C. 701 (1978), aff'd, 638 F.2d. 443 (2d Cir. 1980), aff'd mem. by an equally divided court, 455 U.S. 676 (1982).

professionals will result in lay interference in the professional judgment of licensees, thus causing a decline in quality. They assert that lay corporations such as chain retailers would be unduly concerned with profits, not with the quality of professional care. Allegedly, while such firms might offer lower prices, they might also encourage their professional employees to cut corners in order to maintain profits. The public would suffer doubly, according to those who favor restrictions, because professionals who practice in traditional, non-commercial settings would be forced to lower the price and quality of their services in order to compete.

The Federal Trade Commission's Bureaus of Economics and Consumer Protection have issued two studies that provide evidence that restrictions on commercial practice of optometry -- including restrictions on the business relationships between optometrists and non-optometrists, on commercial locations and on trade name usage -- are, in fact, harmful to consumers. The first study,[12] conducted with the help of two colleges of optometry and the chief optometrist of the Veterans Administration, compared the price and quality of eye examinations and eyeglasses across cities with a variety of legal environments. Cities were classified as markets where advertising was present if there was advertising of eyeglasses or eye exams in local newspapers or "yellow pages." Cities were classified as markets with chain optometric practice if eye examinations were available at large interstate optical firms. Since restraints on corporate practice of optometry, commercial locations and trade name usage necessarily restrict the operations of chain optometric firms, the study provides important information on the likely effects of such restrictions.

The study found that prices charged in 1977 for eye examinations and eyeglasses were significantly higher in cities without chains and advertising than in cities where advertising and chain firms were present. The average price charged by optometrists in the cities without chains and advertising was 33.6% higher than in the cities with advertising and chains ($94.46 versus $70.72). Prices were approximately 17.9% higher as a function of the absence of chains; the remaining price difference was attributed to the absence of advertising.

The data also showed that the quality of vision care was not lower in cities where chain optometric practice and advertising were present. The thoroughness of eye examinations, the accuracy of eyeglass prescriptions, the accuracy and workmanship of eyeglasses, and the extent of unnecessary prescribing were, on average, the same in both types of cities.

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

The second study compared the cost and quality of cosmetic contact lens fitting by various types of eye care professionals.[13] This study was designed and conducted with the assistance of the major national professional associations representing ophthalmologists, optometrists and opticians. Its findings are based on examinations and interviews of more than 500 contact lens wearers in 18 urban areas.

The study found that there were few, if any, meaningful differences in the quality of cosmetic contact lens fitting provided by ophthalmologists, optometrists, and opticians. The study also showed that, on average, "commercial" optometrists -- that is, optometrists who worked for a chain optical firm or advertised heavily -- fitted contact lenses at least as well as other fitters, but charged significantly lower prices.

These studies provide evidence that restrictions on employment, partnership, or other relationships between professionals and non-professionals, on commercial locations and on trade name usage tend to raise prices above the levels that would otherwise prevail, but do not seem to raise the quality of care in the vision care market. Although these studies deal specifically with restrictions on the practice of optometry, the results may be applicable to analogous restrictions in other areas, such as medicine and dentistry.

We also have reviewed Chapter 27, Title 38.1 of the Virginia Code, relating to Plans for Future Dental or Optometric Services, and have identified several provisions that appear to be unnecessarily restrictive or whose anticompetitive effects may outweigh any benefits to the public.

Va. Code Section 38.1-898 requires that a majority of the board of directors of a prepaid dental plan be dentists. It is not apparent what public benefit results from requiring provider control of all plan boards, as this section does.[14] We are unaware of any reason why consumers, entrepreneurs, and others should not also be permitted to establish and operate such plans in competition with provider-controlled plans. Such lay boards can certainly obtain the necessary professional expertise without having providers control the plan's board of directors.

Section 38.1-903 requires that dental or optometric service plan subscribers have "free choice of any participating dentist or optometrist." Some states interpret such clauses to require

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13 Bureaus of Consumer Protection and Economics, Federal Trade Commission, A Comparative Analysis of Cosmetic Contact Lens Fitting by Ophthalmologists, Optometrists, and Opticians (1983).

14 The antitrust laws do not normally prohibit provider control of prepaid health care plans.

that participation be open to any licensed provider. If this section is interpreted in this way, it in fact could restrict the choices available to consumers. Mandating free choice of provider in all prepayment programs prevents plans from offering, and subscribers from freely and voluntarily choosing to enroll in, programs that may limit subscriber choice of provider. Such plans, in turn, may lower program costs by selecting less expensive or more quality-conscious providers, and may generate competitive pressure on all providers to control costs or raise quality. This concept is evident in both health maintenance organizations ("HMOs") and the recent emergence of preferred provider organizations ("PPOs"). As you know, Virginia was one of the first states to pass legislation authorizing PPO arrangements,[15] and the mandatory free choice provision of Section 38.1-903 may be at odds with the purpose and intent of that more recent statute. In its case against the American Medical Association, the Commission found that the origin and history of the medical profession's insistence on this type of provision for prepayment plans "makes clear that the purpose . . . is primarily the anticompetitive one of suppressing the activities of competitors, not solicitude for the rights of patients."[16]

Section 38.1-904 denies the Insurance Commission discretion to license more than one plan in a given geographic area if "licensing more than one plan for the same geographical area will not promote the public welfare." While we do not know how this provision in fact has been applied or will be applied, it could be used to protect current market participants from competition from new market entrants, or at least to discourage such new entry, and would not appear to serve any substantial public interest.

Section 38.1-909 provides that dental plans subject to this chapter "shall not engage in any other business," with the exception of governmental health care programs. This restriction may unnecessarily prevent plans from diversifying and offering their subscribers additional products or benefits packages that may be more convenient and desirable. For example, many commercial insurers have offered coverage packages to employers that include accident and health insurance, dental benefits, life insurance, workers' compensation coverage, and even pensions and annuities. Permitting dental plans to diversify to meet market demands -- subject, of course, to appropriate regulatory oversight -- may allow them to compete more effectively and better meet the needs of the public.

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15 S.B. 110, Chap. 464, 1983 Session (effective July 1, 1983).

16 In re American Medical Association, 94 F.T.C. 701, 1015 (1979), aff'd, 638 F.2d 443 (2d Cir. 1980), aff'd mem. by an equally divided Court, 455 U.S. 676 (1982).

In conclusion, thank you for your willingness to consider our comments. We are enclosing copies of the studies referred to in our comments. Please let us know if we can be of any further assistance.

Sincerely,

Carol T Crawford/HB

Carol T. Crawford
Director

Enclosures
(Sent out separately by DHL).