The FTC Office of Policy Planning Advocacy Program: A Valuable Tool in the Effort to Shape Health Care Policy

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The Office of Policy Planning (OPP) of the Federal Trade Commission (FTC), the office of the FTC focusing on long-range, complex, and cutting-edge legal and policy issues, has focused its advocacy efforts on several health care matters in the past two years.[1] Nearly half of its calendar 2008 and 2009 advocacy filings focused on health care and dentistry, a trend that will continue if the OPP's first filing of 2010 is any indicator.[2] Although OPP has traditionally been described as being lower profile than the enforcement functions of the FTC,[3] advocacy filings by OPP may prove to be an important part of fulfilling the agency's goal of improving competition in health care markets given the current activity in the arena of policy reform. This article aims to provide a brief primer on the history and function of OPP and to highlight several of OPP's most recent advocacy efforts focusing on mobile dentistry and limited service clinics.

Background

The advocacy program of the OPP is based on the submission of comments or letters to state or federal legislative or regulatory bodies considering taking actions that will affect consumers. The FTC has characterized these "government imposed restraints" as being "among the most durable and effective restraints on competition,"[4] and therefore worthy of particular attention. Advocacy submissions are made by request, and typically call attention to the manner in which the contemplated action will affect consumers by applying antitrust principles that may not be familiar to the relevant decisionmakers.[5] The OPP's antitrust analysis may, for instance, demonstrate how a given action could erect barriers to entry or hobble one class of market participants such that consumers will be harmed by diminished access to services or increased prices. The advocacy filings often not only include an antitrust analysis of the contemplated action, but oftentimes substantive research about a given market or practice, reflecting a comprehensive balancing of harms and benefits. One FTC staffer has described OPP's advocacy program as being guided by four principles:

- Will the regulation restriction competition?
- If so, does this provide consumers with a benefit that would otherwise not arise?
- Do consumers value this benefit more than it costs them in lost competition?
- Are there less restrictive ways to reach the same goal?[6]

Because the proponents of the relevant regulations often cite consumer protection as a reason for taking action, OPP's highlighting potential countervailing competitive harm to consumers can give decisionmakers a more accurate and complete picture of the result of taking a proposed action.

The OPP advocacy program is relatively low cost (when compared to the cost of enforcement actions) and has been characterized as an efficient means of promoting the agency's goals.[7] In 2007, the FTC measured the effectiveness of OPP activities by surveying those who had requested the FTC's advocacy input, as well as other parties involved in the process. Looking at OPP filings from 2001 to 2006, the survey concluded as follows:

Fifty-three percent of respondents agreed that the outcome of the regulatory process was largely consistent with the FTC position, 94 percent of respondents said that the FTC comment was considered, and 54 percent of respondents (and 79 percent of those respondents who had an opinion) believed that the FTC comment influenced the outcome. Further, 81 percent of respondents answered that the fact that the comment came from the FTC caused them to give it more weight than they otherwise would have.[8]

Despite this record of effectiveness, the FTC has not used the OPP advocacy program consistently. In existence since the 1970s, OPP has engaged in dramatically varying levels of advocacy activity over the years and had different substantive priorities depending on FTC leadership and historical circumstances. For instance, in the 1980s, when OPP's focus was competition in energy markets, it filed as many as 90 advocacy letters in a given year, with the number

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[1] More information about the Office of Policy Planning can be found on the FTC website. *See* About the Office of Policy Planning, *available at* http://www.ftc.gov/opp/about.shtm.

[2] A complete list of advocacy filings can be found on the FTC website. *See* Advocacy Filings by Date, *available at* http://www.ftc.gov/opp/advocacy_date.shtm (listing eleven unique advocacy filings in 2009, with approximately five in health care or dentistry, and fifteen in 2008, with eight in health care).

[3] *See* Deborah Platt Majoras, *A Dose of Our Own Medicine: Applying a Cost/Benefit Analysis to the FTC's Advocacy Program*, Keynote Address, Current Topics in Antitrust Economics and Competition Policy, Charles River Associates (Feb. 8, 2005), *available at* http://www.ftc.gov/speeches/majoras/050208currebttopics.pdf (describing selected advocacy successes and comparing substantial benefits to limited costs of advocacy program) ("Majoras Address").

[4] The FTC in 2009: Federal Trade Commission Annual Report, at 37 (Mar. 2009), *available at* http://www.ftc.gov/os/2009/03/2009ftcrptpv.pdf.

[5] *Id.*

[6] Gustav Chiarello, Fed. Trade Comm'n Office of Policy Planning, *Regulating the Professions: The Intersection of Competition and Consumer Protection Policies*, Presentation to the Institute of Medicine of the National Academies (Feb. 9, 2009) (presentation slides available at http://iom.edu/Activities/Workforce/oralhealthworkforce/2009-FEB-09/Agenda-Oral-Health-Workforce.aspx).

[7] Majoras Address, *supra* note 3, at 2-3.

[8] FED. TRADE COMM'N, THE FEDERAL TRADE COMMISSION AT 100: INTO OUR SECOND CENTURY 169-70 (Jan. 2009), *available at* www.ftc.gov/os/2009/01/ftc100rpt.pdf (citing *United States, Note for OECD Roundtable on Evaluation of the Actions and Resources of Competition Authorities*, 13-14 (May 25, 2007), *available at* http://www.ftc.gov/bc/international/docs/evalauth.pdf); *see also* Majoras Address, *supra* note 3, at 2-3 (discussing previous efforts to quantify the effectiveness of OPP advocacy program).

of filings falling to under ten per year at times during the 1990s and 2000s.[9]

At least since the 1980s, however, health care and dentistry have remained a consistent focus of OPPs' advocacy program. State laws or regulations aimed at facilitating group contracting by physicians, affecting pharmaceutical benefit management companies and pharmacists generally, regulating dental advertising, or placing restrictions on the health care professions have received particular attention over the years.[10] Two recent debates have received particular attention from the OPP, both of which concern innovative delivery of care and primarily benefit vulnerable or underinsured patients. The first concerned the proposed regulation of in-school mobile dentistry considered by the Louisiana legislature in spring 2009 and subsequently made the subject or rulemaking by the Louisiana State Board of Dentistry. The second addressed the proposed regulation of limited service clinics, appearing more and more in retail and pharmacy environments, in Illinois, Massachusetts, and Kentucky. Both matters illustrate how OPP applies its core principles to respond to proposed legislative and administrative action that stands to threaten competition and consumer welfare.

The FTC Response to Proposed Restrictions on Mobile Dentistry

In May 2009, OPP, along with the Bureau of Competition and Bureau of Economics, submitted comments to the Louisiana legislature concerning a law that would have restricted dentists from providing most in-school dental services. As initially drafted, Louisiana House Bill 687 sought to prevent dentists from providing any in-school dental care unless the service was offered free of charge, i.e., not paid for by Medicaid or another payer. The initial OPP comment,[11] submitted in response to a request from an individual legislator, highlighted the importance of in-school preventive care, citing to secondary sources including studies by the Louisiana Department of Health and Hospitals and the Centers for Disease Control.[12] It also underscored the studies' conclusion that when underprivileged families have to find and obtain dental care outside of the in-school context, many children will not receive preventative care, even though Medicaid will cover the cost of treatment.[13] Finding that the law would "restrict competition to provide underserved juvenile populations routine dental services" despite a lack of "evidence to suggest that the sweeping restrictions on competition found in HB 687 will provide any benefits" or that "for-profit health-care providers provide inferior care to that provided by non-profit providers," the comment concluded by urging the rejection of the bill.[14] Supporters of the law, which included Louisiana's leading professional association of dentists,[15] argued that mobile dentistry reduced the amount of parental involvement in dental care, did not establish an ongoing relationship with a dentist that would improve care, and diminished the ability to control infection.[16]

The lively debate, which spilled over into the press, spurred legislators to amend the bill, converting it from a unilateral ban into a series of specific restrictions.[17] The amendments prompted a second advocacy filing from OPP and the other FTC offices, stating that the amendments appeared "to exacerbate the competition concerns by restricting the market only to present incumbents in many circumstances and raise concerns over the role of competitors in regulating and potentially raising their rivals' operating costs in the Louisiana dental market."[18] Specifically, the comment charged that the amendments allowing in-school dentistry to be performed only by 1) government clinics or 2) private dentists that had been providing in-school care for at least six months of the previous five years, 3) with an exception for schools in "underserved" areas as determined by the Board of Dentistry, would not only harm competition but worsen any claimed problems with the quality of care provided.[19]

The comment pointed out that limiting new market entry to underserved areas would "have a deterrent effect on potential price and quality innovations and improvements that would benefit the children who could receive in-school dental care. Indeed, ... this restriction will serve only to maintain those effects and insulate these providers from competition that could bring improvements to all dental services."[20] Moreover, by allowing the Board of Dentistry to determine what areas were "underserved," the amended bill "thus mandate[d] that, prior to authorizing in-school dental services, competitors on the Louisiana Board of Dentistry must first determine, and then rely on, existing levels of market competition as the primary metric for deciding whether or not in-school dentists may compete."[21] The comment highlighted the "risks to competition when one group of competitors is charged with regulating another," and cited to the FTC's 2007 enforcement against the dental regulatory board in South Carolina regarding a similar restriction on dental services, which resulted in a consent order.[22] Lastly, the comment

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9 Theory and Practice of Competition Advocacy at the FTC, James C. Cooper, Paul A. Pautler, Todd J. Zywicki, presented at the FTC Ninetieth Anniversary Symposium, Sept. 22-23, 2004, *available at* http://www.ftc.gov/ftc/history/90thagenda.shtm.

10 A list of advocacy filings by subject can be found on the FTC website. *See* Advocacy Filings by Subject, *available at* http://www.ftc.gov/opp/advocacy_subject.shtm.678.

11 Fed. Trade Comm'n, Letter to Hon. Timothy G. Burns, Louisiana House of Representatives (May 1, 2009), *available at* http://www.ftc.gov/os/2009/05/V090009louisianadentistry.pdf.

12 *Id.* at 2.

13 *Id.* at 3.

14 *Id.* at 4-5.

15 *See* 2009 Legislative Session Comes to an End (July 8, 2009), website of the Louisiana Dental Association, *available at* http://www.ladental.org/cms/content/blogcategory/16/35/.

16 Jan Moller, *Move to Bar Mobile Dental Clinics Clears First Political Hurdle*, May 12, 2009, Times Picayune, *available at* http://www.nola.com/politics/index.ssf/2009/05/move_to_bar_mobile_dental_clin.html; Legislators Drill Dentists on Proposed Ban, Mark Ballard, May 6, 2009, Baton Rouge Advocate, *available at* http://www.2theadvocate.com/news/44426747.html.

17 Fed. Trade Comm'n, Letter to Hon. Sam Jones, Louisiana House of Representatives (May 22, 2009) ("Jones Letter"), *available at* http://www.ftc.gov/os/2009/05/V090009louisianahb687amendment.pdf.

18 *Id.* at 1.

19 *Id.* at 2.

20 *Id.*

21 *Id.* at 3.

22 *Id.* (citing to the Complaint, Decision and Order, and Analysis to Aid Public Comment, as well as all other pleadings in *In the Matter of South Carolina State Bd. of Dentistry*, FTC Docket No. 9311, *available at* http://www.ftc.gov/os/adjpro/d9311/index.shtm).

criticized the amended bill for allowing all dentist in the state to request and view the records of any patient receiving in-school dental care. Noting that this would allow any dentist "to raise the operating costs of their competitors who provide in-school dental care" by requiring the copying and transmission of records, the comment counseled that the provision could create conditions that would further deter entry by members of an already limited pool of potential providers.[23]

By the time the law arrived on Governor Bobby Jindal's desk for signature, both the initial ban and the restrictions set forth in the amendments were gone, replaced by a charge to the Louisiana Board of Dentistry to promulgate rules governing all portable or mobile dentistry by January 1, 2010.[24] The proposed rules were published in October 2009,[25] prompting yet another comment from OPP and the other FTC offices setting forth the ways in which the proposed rules hinder competition.[26] First, the comment found that the requirement that any dentist performing mobile services first confer with the parent "impose[d] unnecessary burdens on dentists who offer services in a mobile setting," stating that there was no evidence that such a requirement was imposed on dentists performing treatment in an office.[27] "Because all practicing dentists must adhere to the same standards of conduct and care, there seems to be no consumer benefit from this requirement."[28] Second, the comment also found the requirement that providers of mobile dentistry services be subject to unannounced inspections was needlessly discriminatory. Furthermore, because it provided a means for one dentist to "punish" another, the comment found that it could serve as an "invitation" to competitor dentists to act individually or in concert to push a practitioner from the market.[29] Finally, the comment considered the requirement that a mobile dentist provide a parent with a statement indicating that if the child already has a dentist, the child's care should be carried out by that dentist.[30] Calling the requirement a form of "market allocation," the comment found that it "undermines the fundamental principles of competition particularly because it was only to be applied in the mobile setting."[31]

Ultimately, the comment urged the Board to revise its proposed rules, concluding with a classic balancing analysis: while the evidence showed that the rules would likely result in fewer children receiving care, there was little evidence that the rules provided any benefit. "Moreover, if the proposed amendments are necessary to assure patient safety, it is unclear why mobile dentistry offered by federal, state, and local government agencies, as well as free dental care provided in mobile settings are exempt from the rules."[32] Although the comment period closed in December 2009, at the time of publication, it is unclear whether the Board intends to amend or adopt its proposed rules.

The FTC Response to Proposed Restrictions on Limited Service Clinics

As the OPP advocacy filings directed at Louisiana's proposed mobile dentistry restrictions do, OPP's filings challenging state restrictions on so-called limited service clinics ("LSCs") seek to preserve competition in markets in which innovative methods of delivering care stand to benefit vulnerable consumers, including uninsured or underinsured patients.[33] In several matters, the FTC has encouraged decisionmakers through OPP advocacy filings to consider the competitive consequences of restricting the manner in which LSCs may deliver care. In the past few years, the FTC has commented on state efforts to regulate LSCs in Illinois, Massachusetts, and, most recently, Kentucky. All of the filings proceed from the same basic premise: "Store-based health clinics—offering a small, fixed, and publicized range of basic health care services—have the potential to expand access to health care by making very basic medical care convenient and less costly."[34] As described by the FTC, a "typical LSC provides basic screening services (such as cholesterol screening, pregnancy testing, diabetes screening, and strep throat infection testing), administers certain common vaccines (such as flu vaccine), and treats certain basic complaints (such as cold sores, flu, and minor burns and rashes)."[35] Citing studies, the FTC comments demonstrate that the quality of care in LSCs is consistent with services delivered in traditional health care settings while the overall cost of delivering those services is significantly lower.[36]

However, in all three states, the proposed rules would have imposed regulations on LSCs that were not applicable to traditional health clinics. In addition to pointing out that "[i]mposing disparate regulations on competitors can reduce competition among them and thereby harm consumers," the FTC's position highlighted the lack of consumer protection justification for the restrictions of the proposed rules. In Massachusetts, Illinois, and Kentucky, the proposed rules incorporated three types of restrictions: restrictions on the professional services that can be offered at an LSC and how payers may charge for those services; restrictions on how the LSC operates and the space in which it can be located; and other regulatory burdens, such as fees or advertising limits.

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23 Jones Letter, *supra* note 17, at 4.

24 *See* R.S. 37:751, *et seq.* (2009).

25 The proposed rules are located in the Louisiana Register, Oct. 2009, at p. 2226-30, *available at* http://www.doa.louisiana.gov/osr/reg/0910/0910.pdf.

26 Fed. Trade Comm'n, Letter to Barry Ogden, Louisiana State Board of Dentistry (Dec. 18, 2009), *available at* http://www.ftc.gov/opa/2009/12/dentalferc.shtm.

27 *Id.* at 4.

28 *Id.*

29 *Id.* at 5.

30 *Id.*

31 *Id.*

32 *Id.*

33 Fed Trade Comm'n, Comment Before the Kentucky Cabinet for Health and Family Services Concerning the Proposed Regulation of Limited Service Clinics (Jan. 28, 2010) 1 ("Kentucky Letter"), *available at* http://www.ftc.gov/os/2010/02/100202kycomment.pdf.

34 Fed. Trade Comm'n, Letter to Hon. Elaine Nekritz, Illinois Legislature, at 1 (May 29, 2008) ("Illinois Letter"), *available at* http://www.ftc.gov/os/2008/06/V080013letter.pdf; *see also* Fed. Trade Comm'n, Staff Comments to the Massachusetts Department of Public Health Concerning Proposed Regulation of Limited Service Clinics (Sept. 27, 2007) ("Massachusetts Letter"), *available at* http://www.ftc.gov/os/2007/10/v070015massclinic.pdf.

35 Kentucky Letter, *supra* note 33, at 1.

36 *Id.* at 4-5

1. Restrictions on Professional Services, Payer Arrangements

In its 2010 comment on Kentucky's proposed rule governing LSCs, the FTC highlighted the potential for competitive harm to result from proposed "limits on the scope of professional services that may be provided at an LSC—limits that do not apply to the same credentialed professionals in comparable limited care settings."[37] Finding no reason that type of setting should restrict the type of care that a credentialed professional may administer, the FTC illustrated the potential for nonsensical outcomes by citing the provision of the rule that allowed a given professional to conduct a camp- or sports-oriented physical in an LSC setting, but limiting the same professional to conducting school-oriented physicals in non-LSC settings, such as an urgent care clinic.[38] However, perhaps the discriminatory provision with more impact was the ban on treating common, chronic conditions, such as asthma, in an LSC setting.[39]

In its 2008 comments on the proposed Illinois law (House Bill 5372) seeking to regulate LSCs, the FTC also noted the competitive impact of restricting how third-party payers treat the services administered at LSCs.[40] The bill sought to require payers to charge the same co-pays and deductible for services administered in and LSC as in traditional settings. As the FTC pointed out, "differential payments, copayments, and deductible requirements are common across diverse payment and reimbursement arrangements employed by third-party payers, such as "preferred provider organizations," and "[o]ften the promise of such differential payments is critical to the ability of third-party payers to negotiate discounted provider fees."[41] Noting that copayments and deductibles are often a burdensome expense for consumers, the FTC warned against implementing any rule that might increase this burden. Finally, the FTC found that prohibiting payers from providing an incentive for patients to seek care at LSCs could also withhold a cost benefit from consumers.[42]

2. Restrictions on How LSCs May Operate

In its comments on the Illinois bill, the FTC also challenged the consumer protection value of provisions restricting what space LSCs may occupy and how they must use that space. In what might seem like a health-promoting measure, the bill sought to prohibit LSCs from locating in any retail space selling alcohol and tobacco.[43] The FTC, however, found no evidence to suggest that such a measure would promote consumers' health while suggesting that it would "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 raise the clinics' cost if retailers charged more rent to compensate for lost profits on alcohol and tobacco sales.[44] Noting that there was no similar provision for traditional doctors' offices that might be in the same building as a retailer selling tobacco or alcohol, the FTC found the rationale for the restriction "unclear."[45] Also unclear were the rationales for other space-oriented restrictions, such as requiring a receptionist and waiting area in every LSC, which Kentucky also sought to require in its proposed rule.[46]

In its Illinois advocacy filing, the FTC pointed out several drafting ambiguities that, if resolved in a particular way, would result in undue restrictions on the operation of some LSCs. For instance, the FTC noted that one reading of the bill, a provision that apparently sought to exempt traditional physician-owned doctors' offices by distinguishing between LSCs based on ownership, did not take account of the emerging trend of physician-owned LSCs.[47] Under the draft reviewed by the FTC, therefore, the physician-owned LSCs would operate at an advantage when compared to other LSCs. Similarly, ambiguous provisions that appeared to limit the number of LSCs for which a given physician could approve protocols on an annual basis, and with which certain nursing professionals could be affiliated, would potentially advantage larger organizations that have a greater number of unique physicians and nurses to deploy to fill these role at more clinics.[48]

3. Disparate Regulatory Burdens

The FTC advocacy filings also called into question the propriety of extra regulatory burdens placed on LSCs, pointing out the competitive harm of saddling LSCs with extra expenses not incurred by traditional health care providers. The experience of the FTC in the regulation of health care advertising[49] was on display in its advocacy statements addressing a proposed rule before the Massachusetts Department of Health in 2007. Contrary to its usual pro-regulation position, here the FTC challenged the requirement that advertising for LSCs be pre-screened by the state.[50] Drawing specifically on its own expertise and Food and Drug Administration experience in regulating health care advertising, the FTC noted two primary objections to the proposed rule. The first focused on the disparate cost burden placed on LSCs in having to submit to screening, and the potential for the rule to hobble effective operations if changes in hours and services could not be advertised in a prompt manner.[51] The second concern related to the value to consumers of having access to information. The filing noted that while "it is important that regulations aimed at protecting consumers from false or misleading information," regulations must "avoid unnecessarily impeding consumer

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37 *Id.* at 6.

38 *Id.*

39 *Id.* at 6-7.

40 Illinois Letter, *supra* note 34, at 8.

41 *Id.* at 7.

42 *Id.* at 7.

43 *Id.* at 10-11.

44 *Id.* at 10; Kentucky Letter, *supra* note 33, at 6.

45 Illinois Letter, *supra* note 34, at 11.

46 Kentucky Letter, *supra* note 33, at 6.

47 Illinois Letter, *supra* note 34, at 5-6.

48 *Id.* at 6-7.

49 *Id.* at 3 n.13.

50 Massachusetts Letter, *supra* note 34, at 5 (discussing Proposed 105 C.M.R. 140.1001(I)(2)).

51 *Id.*

access to truthful, non-misleading information about the range of available health care services."[52] Advocating an approach of enforcing false advertising laws as opposed to pre-screening, the FTC urged the Department of Health to strike the pre-screening requirement from the proposed rule.[53] In the end, the Department heeded the FTC's advice and struck the pre-screening requirement from the final rule.[54] The FTC made similar comments in its advocacy filing directed at Illinois House Bill 5372, and in it recent comments on the proposed Kentucky rule, which sought to require LSCs, but not traditional clinics, to provide off-hours coverage and defibrillators.[55]

Conclusion

In an era in which health care policy reform is at the fore, both at the federal antitrust agencies and in the nation at large, the targeted efforts of the OPP will be interesting to follow, not only as a harbinger of potential enforcement actions, but as a bellweather for the health care policy priorities and sensibilities of the FTC. If its Louisiana mobile dentistry and LSC-oriented advocacy efforts are any measure, the focus will trend toward the protection of vulnerable consumers and innovation in health care delivery through the preservation of open and vigorous competition.

[52] *Id.* at 6.

[53] *Id.* at 7.

[54] Press Release, Mass. Dept. of Health, Public Health Council Approves Rules for Limited Service Medical Clinics, Jan. 9, 2008; *see also* Final Amendments to 105 C.M.R. 140.1001(I)(2), Jan. 8, 2008, *available at* http://www.mass.gov/Eeohhs2/docs/dph/legal/limited_clinics_final_amendments.doc; Illinois Letter, *supra* note 34, at 4 n.22.

[55] Illinois Letter, *supra* note 34, at 2 n.7; 8; Kentucky Letter, *supra* note 33, at 7.