Federal Trade Commission Opines on Professional Licensing Issues

Reprinted with permission from Citizen Advocacy Center News & Views, Third Quarter, 2011, Volume 23, Number 3.

Citizen Advocacy Center Editorial Note: In recent years, the staffs of the Federal Trade Commission’s Office of Policy Planning, Bureau of Economics, and Bureau of Competition have been asked to comment on legislation and proposed rules related to health professional licensing in several states. This In-Depth Feature contains excerpts from two such comments.

In addition, in June 2010 the FTC initiated an action against the North Carolina Board of Dental Examiners for anti-competitive conduct. Excerpts from the FTC’s complaint also appear below.

This is how the FTC explains its interest in these matters:

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. Competition is at the core of America’s economy, and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality products and services, more choices, and greater innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement, research, and advocacy.

FTC Staff Comment to the Florida House of Representatives on House Bill 4103 and the Regulation of Advanced Registered Nurse Practitioners (ARNPs) – March 22, 2011

... You have asked FTC staff to analyze the “likely competitive impact” of HB 4103, which seeks to replace some of the current constraints on ARNPs’ scope of practice with the less-restrictive supervision requirements that existed in Florida before the 2006 legislation took effect.

Based on current evidence, HB 4103 appears to represent a pro-competitive improvement in the law, one that is likely to benefit Florida health care consumers. As Florida’s Department of Health notes in its own analysis of HB 4103, reducing current supervision requirements “would allow more access to healthcare.” We therefore urge the legislature to consider carefully the impact of the
2006 requirements and to avoid maintaining provisions that would limit ARNP provision of health care services more strictly than patient protection requires. For analogous reasons, we urge the legislature to avoid maintaining undue limits on PA provision of health care services. Unnecessary restrictions on the ability of physicians to supervise ARNPs – or physician assistants (“PAs”) – are likely to reduce the availability, and raise the prices, of the health care services that ARNPs and PAs are able to offer Florida health care consumers. In particular, the current restrictions may impose undue burdens on underserved populations, including rural or inner-city patients or the elderly...

Moreover, the legislative history does not appear to include evidence of particular patient harms that the 2006 legislation was meant to cure. Absent evidence that the heightened restrictions were, and still are, necessary to protect the public, it appears that HB 4103 would benefit Florida consumers by facilitating the provision of lower cost and more accessible health care services...

HB 4103 would remove certain supervision requirements that were adopted in 2006, while retaining the general supervision requirements that predate the 2006 revisions to Florida law. In particular, HB 4103 would eliminate restrictions on how physicians may supervise ARNPs. The Bill would rescind the requirements that (a) a primary care physician may not supervise more than four offices besides his or her primary practice location, (b) a specialist physician – except one who provides dermatologic or skin care services – may not supervise more than two offices besides his or her primary practice location, and (c) a physician providing dermatologic or skin care services may not supervise more than one office besides his or her primary practice location. The Bill also would remove certain reporting and notice requirements imposed in 2006. Likely Effects on Florida Health Care Consumers

... FTC staff concurs with Florida’s Department of Health’s assessment that HB 4103 “would allow more access to healthcare.” By reducing barriers to innovation in health care delivery, the Bill will permit health care providers greater flexibility to offer basic health care through ARNP-staffed clinics. The IOM recently recognized the important role that ARNPs can play in improving access to health care. The IOM also noted, among other things, that “[r]estrictions on scope of practice... have undermined the nursing profession’s ability to provide and improve both general and advanced care.” Increasing the number of ARNP-staffed clinics may also increase competition to provide basic health-care services. For example, ARNP-staffed clinics generally offer weekend and evening hours, providing flexibility for patients. Further, the existence of such clinics may incent other types of clinics to offer extended hours as well. To the extent that HB 4103 increases the deployment of ARNPs in a variety of health care delivery settings, and thereby increases the range of choices available to consumers, the proposed legislation is likely to benefit Florida health care consumers.

ARNPs have, for example, played an important role in the recent proliferation of limited service clinics (“LSCs”) in many states. LSCs typically are staffed by ARNPs – with consultation and supervision commonly provided at a distance, via telemedicine – and offer consumers a convenient way to obtain basic medical care at competitive prices.
Restrictions on oversight and supervision of ARNPs may limit both the number and types of LSCs available to Florida consumers.

**Consumer Protection Concerns and Scope of Practice and Supervision**

Patient safety or consumer protection concerns can justify licensure requirements and scope of practice restrictions. FTC staff recognize that particular health care procedures may require specialized training or heightened supervision if they are to be safely administered. The staff note, however, that the legislative history of the 2006 law does not appear to include any demonstrated patient harms associated with the supervision requirements that had been in force before its enactment or any evidence that the safety of care provided by ARNPs varies according to such requirements. Moreover, the record does not appear to contain evidence supporting uniquely heightened supervision requirements in the general areas of dermatologic and skin care. In addition, there does not appear to be a safety rationale distinguishing the exemption of various practices from the special supervision requirements imposed under the 2006 law. The legislative history suggests, rather, that ARNPs in general are safe providers of health care services within their scope of practice. More broadly, the available empirical evidence indicates that APRN-delivered care “across settings, is at least equivalent to that of physician-delivered care as regards safety and quality.” Studies also indicate that increased ARNP care may be associated with improved outcomes for particular disease indications or patient populations. Studies of limited service clinics—which offer certain basic primary care services and tend to be staffed by ARNPs without direct, on-site physician supervision—indicate that the clinics provide high quality health care.

In addition, studies of ARNP subspecialties, such as certified registered nurse anesthetists, suggest safe delivery of care. Absent evidence that the special restrictions imposed in 2006 are required to address demonstrable patient harms, FTC staff urges that HB 4103 be enacted to remove those restrictions. If particular medical procedures demonstrably require heightened supervision requirements, then staff recommends that the legislature tailor supervision requirements to address those particular services.

**Editorial Note**: A coalition of stakeholders in Florida is attempting to eliminate supervision requirements that apply to ARNPs.

**FTC Staff Comment to the Alabama Board of Medical Examiners on Proposed Regulation of Pain Management Services — November 3, 2010**

...The Proposed Rule restricts the "interventional treatment of pain" to "qualified, licensed medical doctors and doctors of osteopathy," who "may not delegate to non-physician personnel the authority to utilize such procedures to diagnosis [sic], manage or treat chronic pain patients. The rule appears to prohibit certified registered nurse anesthetists (CRNAs) from performing, under the supervision of a physician, pain management procedures that the Board of Nursing considers within the scope of CRNA practice. Absent evidence that the proposed restrictions are necessary to protect the public, there appears to be no reason to sacrifice the benefits of CRNA pain management services as currently available under Alabama law.
Unnecessary restrictions on the ability of physicians to provide pain management services in collaboration with CRNAs are likely to reduce the availability, and raise the prices, of pain management services in Alabama. In particular, the Proposed Rule may burden cancer patients and others with chronic pain, rural Alabamans and others whose access to health care, or ability to pay for it, is limited, and hospice patients.

We therefore urge the Board to consider carefully the impact of the Proposed Rule and to avoid adopting provisions that would limit the role of CRNAs in pain management more strictly than patient protection requires. The Proposed Rule provides no evidence that the current practice has harmed patients. Further, studies that have examined CRNA provision of anesthesia services have not found safety or quality defects in CRNA practice...

Available evidence indicates that CRNAs operating within the scope of their licensure provide pain management services safely. Published data tend to indicate that the baseline risk of anesthesia is extremely low across all providers, and provider settings, with several studies indicating that recent decades have seen "a remarkably abrupt decrease in anesthetic related death rates, morbidity, and risk of perioperative deaths." In publishing its final rule regarding the provision of hospital anesthesia services under the Medicare and Medicaid programs, the U.S. Department of Health and Human Services (HHS) concluded that, "the anesthesia-related death rate is extremely low, and that the administration of anesthesia in the United States is safe relative to surgical risk.” Moreover, HHS found no "need for Federal intervention in State professional practice laws governing CRNA practice... [and] no reason to require a Federal rule in these conditions of participation mandating that physicians supervise the practice of [state-licensed CRNAs]”

Likely Effects on Alabama Health Care Consumers

The Proposed Rule’s restrictions on the ability of physicians to direct and supervise CRNA provision of interventional pain treatments to chronic pain patients practice may increase prices for pain management services and decrease access to such services. By limiting the number of health care professionals licensed to provide pain management services, the Proposed Rule would reduce price competition. Further, prices may rise to the extent that physician services are substituted for lower-cost CRNA services. Finally, the Proposed Rule may thwart innovation in health care delivery by limiting the ability of health care providers to develop, test, and implement the most efficient teams of pain management professionals.

Moreover, the burdens imposed by the Proposed Rule may be felt especially by some of the most vulnerable citizens of Alabama. For example, CRNA practices disproportionately serve smaller, rural hospitals. In addition, hospice providers and patients may face both increased prices and reduced access to care if only physicians can provide palliative care for chronic pain.

It is possible that the Proposed Rule may, on balance, reduce patient safety. As noted, economic or geographic access problems may place some Alabamans at risk of inadequate care. Also, if CRNA pain management specialists are sometimes replaced not by board certified anesthesiologists, but by
physicians and osteopaths who do not specialize in pain management, the average quality of interventional pain management in Alabama, or certain parts of Alabama, could be reduced...

If particular interventional pain treatment services demonstrably require more specialized training and experience than CRNAs working under physician supervision posses, then the Board should tailor the rule to address those particular services. To the extent that there is no evidence that CRNA practice harms patients, staff recommend that the Board reject the Proposed Rule outright.

FTC Complaint against the North Carolina Board of Dental Examiners for Improperly Excluding Non-Dentists – June 17, 2010

... Dentists in North Carolina, acting through the instrument of the North Carolina Board of Dental Examiners ("Dental Board"), are colluding to exclude non-dentists from competing with dentists in the provision of teeth whitening services. The actions of the Dental Board prevent and deter non-dentists from providing or expanding teeth whitening services, increase prices and reduce consumer choice without any legitimate justification or defense, including the "state action" defense. The actions of the Dental Board unreasonably restrain competition and violate Section 5 of the Federal Trade Commission Act.

RESPONDENT

...The Dental Board consists of six licensed dentists, one licensed hygienist, and one "consumer member," who is neither a dentist nor a hygienist. Each dentist member is elected to this position by the licensed dentists of North Carolina, and serves a three-year term. Collectively, the six dentist members can and do control the operation of the Dental Board. Each dentist member is financially interested in decisions reached by the Dental Board because, while serving on the Dental Board, each dentist member continues to engage in the for-profit business of providing dental services.

...The conduct of the Dental Board constitutes concerted action by its members and the dentists of North Carolina.

...The Dental Board is the sole licensing authority for dentists in North Carolina. It is unlawful for an individual to practice dentistry in North Carolina without holding a current license to practice issued by the Dental Board. The Dental Board is also tasked with policing instances of unauthorized practice of dentistry ("UPD") as defined by and pursuant to the North Carolina dental statute...

Teeth whitening services are offered by dentists and non-dentists.

... Many dentists offer patients both in-office teeth whitening services and take-home teeth whitening kits. The most common in-office procedure consists of covering the gums with a protective material, applying to the teeth a hydrogen peroxide solution in the 20 – 35% range, and then exposing the teeth to a light source. Take home kits include a custom-made whitening tray, and a whitening gel that is generally a 15 – 20% carbamide peroxide solution. The consumer self-applies the gel in essentially the same manner as when using an over-the-counter ("OTC") teeth whitening product purchased at, for example, a pharmacy...
Typically, a non-dentist provider operates in the following way. The provider hands a strip or tray containing peroxide to the customer, who applies it to his or her own teeth. The customer's teeth are then exposed to a light-emitting diode ("LED") light source for 15 to 30 minutes. The amount of hydrogen peroxide applied to the teeth at non-dentist outlets generally falls into the 10 – 15% range. This is a greater concentration than OTC products (usually 10% or less), but less than the concentration employed in dentist-applied products (approximately 20 – 35%). The non-dentist provider generally does not touch the customer's mouth.

...Teeth whitening services performed by non-dentists are much less expensive than those performed by dentists. A non-dentist typically charges $100.00 to $200.00 per session, whereas dentists typically charge $300.00 to $700.00, with some procedures costing as much as $1,000.00...

The North Carolina dental statute does not expressly address whether, or under what circumstances, a non-dentist may engage in teeth whitening.

...The Dental Board has decided that the provision of teeth whitening services by non-dentists constitutes UPD. As detailed herein, the Dental Board has acted in various ways to eliminate the provision of teeth whitening services by non-dentists.

...The Dental Board interprets the North Carolina dental statute as permitting non-dentists to engage in the retail sale of teeth whitening products for use at home. However, the Dental Board has determined that any service provided along with a teeth whitening product, including advice, guidance, providing a customer with a personal tray, whitening solution, mouth piece and/or LED light, or providing a location to use the whitening product, constitutes the practice of dentistry...

The Dental Board has engaged in extra-judicial activities aimed at preventing non-dentists from providing teeth whitening services in North Carolina. These activities are not authorized by statute and circumvent any review or oversight by the State.

...On 42 occasions, the Dental Board transmitted letters to non-dentist teeth whitening providers, communicating to the recipients that they were illegally practicing dentistry without a license and ordering the recipients to cease and desist from providing teeth whitening services.

...On at least six occasions, agents of the Dental Board also threatened and discouraged non-dentists who were considering opening teeth whitening businesses by communicating to them that teeth whitening services could be provided only under the direct supervision of a dentist.

...Furthermore, the Dental Board issued at least 11 letters to third parties, including mall owners and property management companies, with interests in approximately 27 malls, stating that teeth whitening services offered at mall kiosks are illegal. The purpose of these letters was to block the expansion of teeth whitening kiosks in shopping malls.

...The Dental Board's exclusion of the provision of teeth whitening services by non-dentists does not qualify for a state action defense nor is it reasonably related to any efficiencies or other benefits sufficient to justify its harmful effect on competition...
The exclusionary course of conduct of the Dental Board... may be expected to continue in the absence of effective relief. As a consequence of the challenged actions and course of conduct of the Dental Board, the availability of non-dentist teeth whitening services in North Carolina has been and will be significantly diminished...

The challenged actions and course of conduct of the Dental Board have had and will have the effect of restraining competition unreasonably and injuring consumers in the following ways, among others:

- preventing and deterring non-dentists from providing teeth whitening services in North Carolina;
- depriving consumers of the benefits of price competition; and,
- reducing consumer choice in North Carolina for the provision of teeth whitening services...

The combination, conspiracy, acts and practices described above, constitute anticompetitive and unfair methods of competition in or affecting commerce in violation of Section 5 of the Federal Trade Commission Act, as amended, 15 U.S.C. § 45. Such combination, conspiracy, acts and practices, or the effects thereof, are continuing and will continue or recur in the absence of appropriate relief.

*Editorial Note: See [http://administrativelaw.ncbar.org/] for a commentary on this complaint and briefs filed by the FTC and the board by Jeff Gray, a North Carolina trial attorney practicing with the firm Bailey and Dixon, LLP. Note his comment that “In the opinion of this author, the biggest threat to the State occupational and professional licensing boards and commissions in North Carolina, or in any state nationally that has similar statutorily created regulatory scheme, is that this suit threatens the immunity previously enjoyed by these boards and commissions.”

The dental board countersued on February 1, 2011, alleging that the FTC had exceeded its authority. This suit was dismissed on May 3, 2011, on a jurisdictional technicality.

*In addition to its comments on scope of practice restrictions by individual licensing boards, the FTC staff has also commented several times on proposed state-based restrictions on retail clinics. Illustrative is the letter sent to the Kentucky Cabinet for Health and Family Services (CHFS) dated January 28, 2010. An FTC press release described the letter this way:

FTC Staff Comment to the Kentucky cabinet for Health and Family Services on Proposed Regulations for Licensing Retail Clinics Raise Competitive Concerns – January 28, 2010

What follows is the press release announcing the FTC staff’s letter to the Kentucky officials.

The Federal Trade Commission’s staff has sent a letter to the Kentucky Cabinet for Health and Family Services (CHFS) stating that certain new regulations proposed for the licensing of “limited service clinics” (LSCs) in the state raise competitive concerns and are likely to increase the cost of health services for Kentucky consumers, particularly the uninsured. LSCs – which are sometimes
called “retail clinics” or “store-based clinics” – are one way to deliver a limited range of basic health care services in a clinic setting.

The proposed rule would regulate the operation of LSCs in Kentucky. While many provisions of the proposed rule mirror basic consumer protection standards in other states and do not raise competitive concerns, according to the FTC staff comments, several provisions impose distinct costs and restrictions on LSCs, but not on other limited-care operations such as urgent care centers.

According to the comments, those provisions would limit the scope of professional services that licensed health care professionals could provide at Kentucky LSCs, would impose physical or operational restrictions on LSCs but not comparable limited-care settings, and would impose on LSCs licensing fees greater than those imposed on all other categories of health care facilities. Each provision could limit market entry by LSCs, reducing competition from LSCs on the price, convenience, and availability of basic health care services in the state, the staff concludes. Health and safety consumer protection benefits can offset the costs of potentially anticompetitive regulations, but there is no evidence that the discriminatory provisions in the proposed rule are likely to provide such benefits.

The staffs of the Office Policy Planning, Bureau of Competition, and Bureau of Economics submitted the comments, which can be found on the FTC’s Web site and as a link to this press release, on January 28, 2010, in response to a call for public comments from the CHFS’s Office of Inspector General.

The FTC vote approving the staff letter was 4-0. (FTC File No. V100007; the staff contact is Daniel J. Gilman, Office of Policy Planning, 202-326-3136. See related press release dated October 2, 2007, at http://www.ftc.gov/opa/2007/10/massdphe.shtm.)

More information about these FTC actions can be found on the Commission’s Website: http://www.ftc.gov/.

Since 1987, CAC has been serving the public interest by enhancing the effectiveness and accountability of health professional oversight bodies. CAC offers training, research and networking opportunities for public members and for the health care regulatory, credentialing, and governing boards on which they serve.