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

OFFICE OF
CONSUMER AND
COMPETITION ADVOCACY

February 26, 1992

George L. Schroeder
Director
Legislative Audit Council
400 Gervais Street
Columbia, South Carolina 29201

Dear Mr. Schroeder:

The staff of the Federal Trade Commission[1] is pleased to respond to the invitation of the Legislative Audit Council of the State of South Carolina to comment on possible restrictive or anticompetitive practices in the statutes and regulations of the South Carolina Board of Pharmacy, Board of Medical Examiners, Board of Veterinary Medical Examiners, Board of Nursing, and Board of Chiropractic Examiners.

The statutes and regulations incorporate standards and requirements that raise only a few competition issues. Some of the statutes and regulations contain provisions that are clearly procompetitive in intent and effect, but features of others could raise competition concerns. These are discussed below.

I. Interest and experience of the staff of the Federal Trade Commission

The Federal Trade Commission is empowered by statute to prevent unfair methods of competition and unfair or deceptive acts or practices in or affecting commerce.[2] Pursuant to this mandate, the Commission encourages competition in the licensed and regulated professions to the maximum extent compatible with other state and federal goals. The staff of the Commission works to identify restrictions that hinder competition and increase costs without providing countervailing benefits to consumers.

For more than a decade, the Commission and its staff have investigated the competitive effects of restrictions on the

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[1] These comments represent the views of the staff of the Federal Trade Commission. They are not necessarily the views of the Commission or those of any individual Commissioner.

[2] Federal Trade Commission Act, 15 U.S.C. § 41 et seq.

business practices of state-licensed professionals, such as lawyers, dentists, physicians, pharmacists, and other non-physician health care providers. In addition, the staff has submitted comments to state legislatures and administrative agencies, including seven previous comments to the Legislative Audit Council of South Carolina.[3] As one of the two federal agencies with principal responsibility for enforcing antitrust laws, the Commission is particularly interested in restrictions that may adversely affect the competitive process and raise prices to consumers.

II. Analysis of Statutes and Regulations

All of boards about which you have asked for comment are engaged in licensing and regulating providers of health care services. Some of our previous comments to the South Carolina Legislative Audit Council have discussed the general issues and problems raised by occupational licensing and regulation.[4] Occupational regulation may promote or assure a standard of service quality to consumers, especially when judging quality is substantially more difficult for consumers than for providers. Regulation may also counter the problems raised when a professional's services may affect third parties and the risk that the combination of

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[3] In comments filed from February 1987 through November 1989, the staff commented on statutes and regulations pertinent to the Board of Optometry and Opticianry (February 19, 1987); Board of Podiatry Examiners, Board of Occupational Therapy Examiners, Board of Speech and Audiology Examiners, and Board of Psychology Examiners (April 23, 1987); Public Service Commission (September 29, 1987); Licensing Board for Contractors, Residential Home Building Commission, Real Estate Commission, Board of Certification for Environmental System Operators, Board of Registration for Professional Engineers and Land Surveyors, and Manufactured Housing Board (January 15, 1988 [1987]); Board of Registration for Landscape Architecture, Board of Architectural Examiners, Board of Funeral Service, Board of Examiners for Registered Sanitarians, Board of Social Work Registration, State Cemetery Board, Building Code Council, Board for Barrier Free Design, and Athletic Trainers Advisory Committee (January 23, 1989); Board of Architectural Examiners (March 13, 1989); and Commissioners of Pilotage for the Port of Charleston, Auctioneers' Commission, and Board of Registration for Foresters (November 7, 1989).

[4] See letters from the Bureaus of Economics, Competition, and Consumer Protection to the Legislative Audit Council of September 29, 1987, and January 15, 19[88]; see also C. Cox and S. Foster, The Costs and Benefits of Occupational Regulation, Bureau of Economics Staff Report, October, 1990.

"diagnosis" and "prescription" may lead to abuses. But licensing and regulation are not the only ways to address these concerns. For example, consumers may obtain information about service quality from experience, advertising, and reputation, as well as from the assurances provided by licensing and regulation.

Restrictions on professional practice do not always achieve their purpose of raising quality. Many studies have found little relationship between restrictions on professional practice and the quality of care provided.[5] And whatever the effect on quality, licensing and regulation come at a cost, in potentially higher prices, reduced service, and dampening of competition, that should be weighed against their benefits.

A. Board of Pharmacy[6]

One problem often encountered when professionals regulate their own profession is that they may adopt and impose rules to prevent competition. The statutes and regulations of the Board of Pharmacy deal explicitly with this problem, by forbidding the Board of Pharmacy to regulate several aspects of normal commercial competition. The Board may not regulate prices,[7] hours of operation, or hours of work.[8] Retail price advertising is permitted explicitly.[9] The Board's licensing decisions cannot be based on the amount of competition in the market.[10] And out-of-state mail-order pharmacies are permitted to compete with local pharmacies. Thus, South Carolina has already considered some of the competition problems that might arise in this regulatory scheme and taken steps to prevent them.

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[5] See Cox and Foster, supra n. 4.

[6] S. C. Code Ann. §§40-43-10 – 40-43-380; S.C. Code Regs. 26, ch. 99. The Board is constituted by political appointment from nominees selected by and from the professional pharmacists subject to the Board's authority.

[7] S. C. Code Ann. §40-43-130.

[8] S. C. Code Ann. §40-43-200.

[9] S. C. Code Ann. §40-43-460.

[10] Out-of-state mail-order pharmacies are subject to certain additional regulations, about local licensing, supervisory requirements, and telephone access to records, but these do not appear unreasonable. S. C. Code Ann. §40-43-425.

The statute and regulations also address another issue, physician dispensing, that is often encountered in pharmacy regulation. South Carolina generally permits physicians (and other health care providers) to dispense their own prescriptions.[11] Physician dispensing may expand consumers' options for purchasing prescription medicines, leading to increased competition among physicians and between physicians and pharmacists. By increasing competition, physician dispensing can lead to lower prices and better services. But it is not free of risks. Physicians who dispense for profit may be led by their own financial interests to overprescribe or prescribe inappropriately. Such abuses might be dealt with, not by prohibiting physician dispensing, but by disciplining physicians who prescribe inappropriately. In general, we support allowing the consumer to choose among qualified providers, and thus we do not find competition problems in South Carolina's approach.

B. Board of Medical Examiners[12]

Two aspects of the current regulations governing physicians raise competition concerns.[13] The regulation against soliciting patients[14] appears to prohibit even non-coercive solicitation and could prohibit truthful, non-deceptive advertising. And the prohibition of commissions or referral fees[15] could restrain competition unduly, by inhibiting cost-saving and procompetitive

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[11] Dispensing is permitted by physicians, dentists, podiatrists, veterinarians, and hospitals dispensing to in-patients. S. C. Code Ann. §40-43-100; §40-43-150; §40-43-360 (exempting a doctor's office from the definition of a "drug outlet" requiring a pharmacy permit); §40-43-430. Emergency room physicians can only dispense a 72-hour dose. §40-43-100.

[12] S. C. Code Ann. §§40-47-5 – 40-47-201; S. C. Code Regs. 26, ch. 81. An osteopath is on the Board, but participates in licensing decisions only for osteopathy. See §§40-47-10, 40-47-50, 40-47-120, 40-47-180.

[13] The Commission has conducted an investigation of the Board of Medical Examiners' regulations. That investigation closed without the Commission reaching any final determination whether the restrictions discussed below violated Section 5 of the FTC Act.

[14] Regs., §81-60, Principle E, enforced pursuant to Regs. §81-1.

[15] Id., Principle G.

practices.[16] However, we understand that the Board of Medical Examiners has proposed substantially revised regulations that eliminate these provisions completely. The Board's proposal has been submitted to the legislature, and these new regulations may become effective in 120 days from that submission unless the legislature moves to reject them.[17] The following comments are addressed to issues raised by the present regulations.

Advertising and solicitation can be useful sources of information to consumers and can provide them with truthful, nondeceptive information about terms of services that will help them select a physician (or other professional). Direct contacts can convey information about the availability and terms of services and, in this respect, they serve much the same function as print advertising. To be sure, some kinds of solicitation may not serve the individual's and society's interest in informed and reliable decisionmaking; thus, a regulation that was appropriately limited, such as one that prohibited solicitation aimed at certain kinds of patients vulnerable to undue influence, could be beneficial. But the present South Carolina regulation, which states simply that a physician "should not solicit patients," could raise very serious competition problems. It restates literally a ban on solicitation once found in the American Medical Association's Principles of Medical Ethics, which was the foundation of an AMA ban on advertising that the Commission held to be a violation of the Federal Trade Commission Act.[18] The Board of Medical Examiners' proposed new regulation would not present these problems, because it contains no restriction on advertising or solicitation.

The proposed new regulations would also eliminate the present regulations' ban of referral fees. Such restrictions can interfere with legitimate business affiliations between practitioners and

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[16] The rule against practicing "under terms or conditions which tend to interfere with or impair the free and complete exercise of [the physician's] medical judgment and skill or tend to cause a deterioration of the quality of medical care," although not necessarily objectionable, could be problematic if it were interpreted to prohibit alternative forms of professional practice. Id., Principle F. See n. 17, infra.

[17] S. C. Code Ann. §§1-23-120, 1-23-125.

[18] American Medical Ass'n, 94 F.T.C. 701 (1979), enforced as modified, 638 F.2d 443, 451 (2d Cir. 1980), aff'd by an equally divided Court, 455 U.S. 676 (1982). The Commission also found that rules based on the AMA's Principle corresponding to current Principle F, see n. 16, supra, violated the FTC Act. The Commission found that the rules had been intended to eliminate contract practice. 94 F.T.C. at 1011-1015.

other persons or entities and with the flow of useful, nondeceptive information to consumers about providers. Thus, restrictions on referral fees should not be broader than necessary to protect the public from harm.[19]

The primary justification usually offered for restrictions on referral fees is that they prevent abuse of the special trust that a patient places in a physician to make appropriate referrals based on independent professional judgment of the patient's best interest. An unscrupulous practitioner who stands to receive a referral fee from another provider might possibly refer the patient for unnecessary health care. Even in the case of necessary care, such a physician might be tempted to refer a patient to the provider who pays the highest referral fees, rather than to the most competent one. On the other hand, if it is not possible to pay or receive referral fees, some doctors may provide certain services themselves rather than refer patients to other doctors, offering referral fees, who can provide better quality care.

Harm to patients from referral fees is less likely when referrals are made among providers in an integrated operation such as a health maintenance organization (HMO) or preferred provider organization (PPO). Fees paid to these entities are unlikely to provide an incentive for anyone to refer patients for unnecessary care, since the entity receiving the fee does not receive additional fees for each referral.

Overbroad restrictions on referral fees may interfere with the operation of alternative health care delivery systems (such as HMOs and PPOs) that may have incentive arrangements with health care professionals in which fees are divided between the medical plan and the professionals. Such restrictions may also prevent practitioners from participating in commercial referral services that charge a fee for participation. Referral services can be valuable in helping consumers locate appropriate health care alternatives and, by facilitating the gathering of information, such services can increase competition among health care professionals. In such situations, disclosure of the fact that the provider will pay or receive a fee in consideration for a referral could help to prevent abuse or deception and to protect patients from harm. Such disclosure could also provide patients with information to aid in their decision whether to use the recommended provider.

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[19] How a restriction is interpreted and applied can be important in assessing its competitive effects. Even a narrowly tailored restriction, for example, could have adverse effects if broadly applied.

The treatment of referral fees under federal laws that govern "kickbacks" in the context of Medicare and Medicaid reimbursement is instructive.[20] Recently, the Department of Health and Human Services issued regulations defining "safe harbors," that is, practices that HHS would not consider violations of the anti-kickback law.[21] In announcing these regulations, HHS recognized that certain payments in connection with the services of HMOs, PPOs, and referral services are not necessarily contrary to the policies addressed by the anti-kickback law. Thus, under the regulations, payments for a referral service do not violate the law as long as the referral service meets certain requirements and discloses the fees to those using the service. One of the requirements is that the fee compensate for the cost of operating the service and not be dependent on the volume or value of referrals subject to Medicare or Medicaid reimbursement. Further regulations are being prepared to define safe harbors specifically for HMOs and PPOs. "Payments," such as waiving co-payment obligations, to induce people to use the services of such organizations could otherwise be considered violations of the anti-kickback law. Such routine waivers by these organizations are recognized as "inextricably intertwined" with their offering a comprehensive package of benefits, and not as inducements to purchase individual items or services.[22]

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[20] The "Medicare Anti-Kickback Statute," Section 1128B(b) of the Social Security Act, 42 U.S.C. 1320a-7b(b), makes it a felony to make certain kinds of payments intended to induce the referral of business payable under Medicare or Medicaid. P. L. 101-239, effective January, 1992, sets the law applied to referrals to physician-owned clinical laboratories. See Section 6204, §1877 of the Social Security Act. The regulations described in the text apply only to the Medicare Anti-Kickback Statute.

[21] 56 Fed. Reg. 35,952 (July 29, 1991).

[22] 56 Fed. Reg. at 35,961. The new rules will apparently treat differently those prepaid plans that have contracts with the federal or state health care financing agencies and those that do not, because the government agencies have more control over the organizations with which they contract. More comments are being sought before these rules will be issued. Id.

C. Board of Veterinary Medical Examiners[23]

Unlike the regulations governing physicians, the regulations governing veterinarians contain nc separate code of ethics.[24] But one of the issues, restraints on advertising, that is implied by the physicians' regulations is dealt with explicitly in the statute governing veterinarians. South Carolina law permits veterinarians to advertise as long as the advertising is not "knowingly untrue, fraudulent, misleading, or deceptive."[25] But another prohibition may make that permission less effective: veterinarians may not use "solicitors or peddlers to obtain patronage."[26]

We have endorsed proposals to remove burdensome restrictions on the ability of veterinarians to advertise, and have opposed banning the use of solicitors.[27] A rule against using solicitors may impede the flow of truthful commercial information from veterinarians to potential clients. Such restrictions on the free flow of truthful information may make it more difficult for buyers to learn about differences in price and quality, thereby insulating competitors from direct competition. Of course, solicitors may be held to the same standard of conduct as the professionals that they represent, and a past pattern of abuses may warrant regulations tailored to prevent specific abuses. But a blanket ban on the use of solicitors may be too broad.

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[23] S. C. Code Ann. §§40-69-10 – 40-69-220; S. C. Code Regs. 27, ch. 120. The selection procedure is similar to that for the other Boards. The non-professional member is styled a "consumer advocate" member and does not participate in licensing decisions.

[24] The code of the American Veterinary Medical Association is mentioned in the statute as a guide, but it is not incorporated in the law or regulations. S. C. Code Ann. §40-69-70(2).

[25] S. C. Code Ann. §40-69-140(10).

[26] S. C. Code Ann. §40-69-140.

[27] See letters from the Bureau of Consumer Protection to Virginia Board of Veterinary Medicine (April 10, 1986) and Virginia Department of Health Regulatory Boards (September 14, 1984). In addition to these staff comments on regulations, Commission law enforcement proceedings have also considered these issues. The Commission recently issued a consent order against an Alabama veterinary association that imposed advertising restrictions. Madison County Veterinary Medical Ass'n, FTC Dkt. No. C-3340 (Aug. 16, 1991).

D. Board of Nursing[28]

No competition problems were found in the statute or regulations governing nursing.

E. Board of Chiropractic Examiners[29]

The Board's powers include the power to adopt regulations about patient solicitation and advertising. The statute establishes no limits on that power, except that the Board may not prohibit or discriminate as to advertising in any particular medium.[30] The Board's regulations ban only advertising that is false or misleading (or that has a tendency to be false or misleading).[31] As long as "tendency" is not interpreted to ban truthful and nondeceptive commercial speech, these regulations appear to pose no competition problems.[32]

III. Conclusion

We are pleased to have this opportunity to present our views on these medical occupational licensing statutes and regulations of the State of South Carolina. For the most part, we have not found major competition problems raised by these materials. The present regulations concerning physician solicitation and referral fees could raise serious competition problems, but we understand they are likely to be replaced soon by new Principles of Medical Ethics

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[28] S. C. Code Ann. §§40-33-10 – 40-33-50; S. C. Code Regs. 26, ch. 91.

[29] S. C. Code Ann. §§40-9-10 – 40-9-110; S. C. Code Regs. 23A, ch. 25.

[30] S. C. Code Ann. §40-9-30(3). Although this section of the statute authorizes regulations about solicitation, the Board of Chiropractic Examiners has not adopted a regulation of solicitation comparable to the one contained in the current regulations of the Board of Medical Examiners, discussed in Section II.B. above.

[31] Regs., §25-12(5).

[32] The separate "Advertising Guidelines," dealing with insurance, also appear to pose no problems. By prohibiting chiropractors from submitting claims to third-party insurers for services advertised as "free," or for amounts greater than what is actually charged as a usual and customary fee, the guidelines apparently merely require chiropractors to deal honestly. Regs., §25-13.

in which the restrictions have been removed. We suggest that the regulations about veterinarians' use of solicitors be studied to determine whether they are having an anticompetitive effect in practice.[33]

Sincerely,

Michael O. Wise
Acting Director

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[33] The staff has reviewed the statutes and regulations governing five licensed occupations. In view of the volume of the materials involved, it is possible that some potentially anticompetitive provisions have escaped our attention. If the Legislative Audit Council has questions concerning provisions not discussed in this letter, please contact us for further review.