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

Office of Policy Planning
Bureau of Competition
Bureau of Economics

May 25, 2012

The Honorable Stephen LaRoque
Representative, North Carolina House of Representatives
Legislative Office Building
300 North Salisbury Street, Room 635
Raleigh, NC 27603-5925

Dear Representative LaRoque:

The staffs of the Federal Trade Commission's ("FTC" or "Commission") Office of Policy Planning, Bureau of Competition, and Bureau of Economics[1] appreciate the opportunity to respond to your invitation to comment on North Carolina House Bill 698 ("the Bill" or "H.B. 698"),[2] a Bill that would impose significant restrictions on the business organization of dental practices in North Carolina. You have explained that, within the state's existing statutory framework for the licensing of dental professionals and the provision of dental services,[3] Dental Service Organizations ("DSOs") have successfully operated in North Carolina "for over thirty years and assist dentists and dental practices with a variety of the non-clinical aspects of operating a successful practice, including accounting, bookkeeping, scheduling services, procurement, and the like."[4] You have noted that the additional restrictions proposed in H.B. 698 "would significantly undermine the DSO model," and you have asked FTC staff to analyze "the potential competitive implications of the proposed legislation."[5]

We are concerned that the Bill may deny consumers of dental services the benefits of competition spurred by the efficiencies that DSOs can offer, including the potential for lower prices, improved access to care, and greater choice. Underserved communities, such as the 78 of 100 counties in North Carolina that are listed as Dental Health Professional Shortage Areas, may be particularly affected if DSO efficiencies cannot be realized. Therefore, we urge you to consider whether the Bill's restrictions and grants of regulatory power to the North Carolina Board of Dental Examiners ("Board") are necessary to protect consumers. If not, the North Carolina legislature should reject the Bill.

Consumers benefit when health professionals can organize their practices in the way they find most efficient, consistent with quality care. Licensed dentists contract with DSOs to obtain a variety of back-office, *non-clinical* functions, allowing these dentists to focus primarily on the treatment of patients, and less on the business management aspects of running a dental practice. In North Carolina and other states, DSOs appear to help licensed dentists maintain efficient business operations, allowing the dentist to focus more on treating patients.

The proposed legislation states that it is "An Act To Require That Dentist Agreements With Management Companies Do Not Shift Control Of Clinical Patient Services Away From Licensed Dentists." Current North Carolina law, however, already prohibits unlicensed persons from performing certain clinical dental procedures as defined in the law, and also prohibits unlicensed persons from owning, managing, supervising, controlling, or conducting "any enterprise wherein one or more of the [clinical] acts or practices" are done.[6] Thus, to the extent the North Carolina legislature already has found this to be a legitimate concern, the provisions of the Bill addressing it would appear to be redundant with the current law in North Carolina.

The Bill's provisions that go beyond this purpose appear to give the Board significant new regulatory and oversight authority over DSOs operating in North Carolina. The Board would gain exclusive authority to review and approve every DSO management agreement between any North Carolina-licensed dentist or professional entity and a management company.[7] Moreover, the Bill would prohibit management agreement provisions currently used in North Carolina and other states. The Board could apply these new restrictions and oversight powers not only to eliminate entry by new DSOs into North Carolina, but also to dismantle existing DSOs operating in the state by refusing to approve management agreements when they come up for renewal. Indeed, there is already some evidence that the Board is taking steps to do this. For example, the Board recently took action under its current authority against a dentist who attempted to affiliate with a potential DSO entrant, and prohibited the DSO from entering North Carolina for five years. The Board explicitly conceded there were no allegations the dentist, who had practiced dentistry since 1977, was providing negligent or low quality care.[8] FTC staff urge you to consider whether this kind of Board action is more likely to recur if the Bill passes, and whether it reliably protects consumers or risks merely protecting those dentists who do not choose to use DSOs against competition from those who do. Given that the state's existing licensure framework already enables the Board to oversee health and safety issues, and in the absence of evidence regarding safety concerns specific to the use of DSOs, the Bill appears likely to do more harm than good.

I. INTEREST AND EXPERIENCE OF THE FTC

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.[9] Competition is at the core of America's economy,[10] 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.

FTC staff have particular experience with issues related to dental competition.[11] More generally, FTC staff have investigated and reported on the competitive effects of restrictions on the business practices of state-licensed professionals, including dentists, optometrists, physicians, pharmacists, and veterinarians.[12] In addition, staff have submitted comments about the competitive effects of restrictions on the business practices of state-licensed professionals to state legislatures, administrative agencies, and others.[13]

The Commission has challenged rules prohibiting professionals from entering into business relationships with non-professionals when such rules were imposed by an entity subject

to the Commission's law enforcement jurisdiction. For example, the Commission found that the American Medical Association's (AMA) ethical code provisions, which prohibited physicians from working on a salaried basis for hospitals or other lay institutions and from entering into partnerships or similar business relationships with non-physicians, unreasonably restrained competition and violated federal antitrust laws.[14] The Commission also found there were no countervailing procompetitive justifications for these restrictions. The Commission concluded the AMA's prohibitions kept physicians from adopting potentially efficient business formats and precluded competition from organizations not directly and completely under the control of physicians.[15]

II. THE IMPORTANCE OF ACCESS TO DENTISTS, AND THE NEED FOR IMPROVED ACCESS IN NORTH CAROLINA

The U.S. Surgeon General has found that "'a silent epidemic' of oral diseases" affects our nation's most vulnerable citizens, including children.[16] Populations that have trouble accessing adequate dental care include the poor, African Americans, Hispanics, children insured by Medicaid and the Children's Health Insurance Program, residents of rural areas, people with disabilities, and migrant and seasonal farmworkers.[17] The Centers for Disease Control estimates that tooth decay affects more than one-fourth of U.S. children ages two through five, and half of U.S. children ages twelve through fifteen; children and adolescents from lower-income families, as well as from certain racial and ethnic groups, have the highest rates of untreated tooth decay.[18]

According to a recent report by the Institute of Medicine ("IOM") – established in 1970 as the health arm of the National Academy of Sciences to provide expert advice to policy makers and the public – tooth decay is "more than five times as common as asthma among children ages 5 to 17. Evidence shows that oral health complications may be associated with adverse pregnancy outcomes, respiratory disease, cardiovascular disease, and diabetes. For the most part, tooth decay is a highly, if not entirely, preventable disease."[19]

Another recent report noted that "preventable dental conditions were the primary diagnosis in 830,590 visits to [emergency rooms] nationwide in 2009" and for "many low-income children, emergency rooms are the first and last resort because their families struggle to find a dentist who either practices in their area or accepts Medicaid patients."[20] "In 2009, there were more than 69,000 ER visits to North Carolina hospitals due primarily to disorders of the teeth or jaws."[21]

In 2010, there were approximately 4,180 dentists practicing in North Carolina. This amounts to 4.4 dentists per 10,000 people, compared to an average ratio in the United States of 5.7 dentists per 10,000. The state has historically ranked near the bottom of the fifty states in terms of dentist-to population ratio.[22] In 2007, for example, forty-six states had a higher ratio of dentists-to-population than North Carolina.[23] All or portions of 78 out of 100 counties in North Carolina are listed as Dental Health Professional Shortage Areas,[24] and four counties have no actively practicing dentists.[25]

III. THE DSO BUSINESS MODEL AND KEY CHANGES THAT WOULD BE IMPOSED BY H.B. 698

DSOs have operated successfully and safely in North Carolina for over thirty years, including operations under the existing regulatory framework.[26] For example, one dentist who currently works with a DSO described how he and his business partner realized they learned little in dental school about running a business. Therefore, as he explained, "like many small-business owners, we looked to outside companies to help finance the practice, manage billing, handle payroll, file insurance and execute other administrative tasks. The arrangement helped our dental practice operate so efficiently that we can charge lower rates and accept dental insurance from patients."[27]

The same dentist noted that if the proposed Bill were to pass, "[m]any dentists like [him] would be forced to spend less time on patient care and more time on managing the complexities of a modern dental practice."[28] H.B. 698 would impose a new set of restrictive and burdensome regulations on DSOs, including the following:

- First, H.B. 698 would give the Board exclusive authority to review and approve every DSO management agreement between any North Carolina-licensed dentist or professional entity and a management company.[29]

- Second, H.B. 698 would prohibit specific management agreement provisions (including some commonly used today), or regulate these provisions in a manner too vague to provide meaningful guidance.[30]

- Third, H.B. 698 would give the Board full control over the timing of, and procedure for, the Board's review.[31] The Board also would control disciplinary proceedings against any party that enters into a management agreement without Board approval.[32]

- Fourth, H.B. 698 would give the Board the right to randomly audit, inspect, and investigate "the management agreements and the books and records of any management company which enters into a management arrangement with a licensed dentist or professional entity."[33] If the Board were to find that a management company or dentist was non-compliant with the law, it could schedule periodic audits, inspections and investigations "to help ensure ongoing compliance."[34] The management company and/or dentist would be responsible for the Board's audit costs, "including the reasonable costs of attorneys, accountants, or other professional consultants employed or retained by the Board to conduct or assist in the process."[35]

- Finally, although H.B. 698 includes confidentiality provisions for material that the Board would collect during its review, this information could become public if it were entered into evidence during a Board hearing.[36]

IV. LIKELY COMPETITIVE EFFECTS OF H.B. 698

When licensed dentists contract with DSOs to provide nonclinical services to their dental practices, DSOs appear to increase efficiency and support entry by new dental practices, which may lead to lower prices, expanded access to dental services, and greater choice for dental consumers. The proposed Bill likely would prevent dental consumers from receiving these potential benefits of competition, in at least two ways:

- The specific contract restrictions in the legislation, as well as the requirement that the Board approve all dentist/DSO contracts before they can be implemented or continued upon renewal, are likely to eliminate new DSO entry in North Carolina and seriously impede existing DSOs operating in the state.[37]

- To the extent DSOs can continue to operate in North Carolina, the Bill's auditing and information-gathering provisions may drive up DSO costs, and also increase the likelihood that pricing or other sensitive information will be shared among competing dental practices.

FTC staff recognize that certain professional licensure requirements are necessary to protect consumers – especially consumers of health care services, who may rely on licensure for safety and quality assurances. But health care consumers also benefit from competition among health care professionals.[38] Competition spurs both current providers and potential entrants to develop more efficient ways to offer their services, without compromising quality. For these reasons, in health care markets as in other markets, sound competition policy dictates that competition should be restricted only when necessary to protect the public from significant harm, and restrictions should be narrowly crafted to minimize their anticompetitive impact.[39]

Laws and regulations governing licensed and regulated businesses may seek to limit different types of "commercial practices." For example, laws and regulations may prevent licensed professionals from entering into employment or other commercial relationships with non-licensed persons or firms. Proponents of these types of restrictions have often argued that these limits are necessary to maintain quality of service and protect the professional's independent judgment, even though "the majority of studies find quality to be *unaffected* by licensing or business practices" and in "some cases quality actually decreases" in response to the restrictions.[40] In the absence of safety justifications for business format restrictions, it becomes particularly important to evaluate their likely competitive effects, including reduced competition, decreased access, and potentially higher prices.[41] These types of restrictions may suppress the development of innovative and efficient models of professional practice, which could compete against traditional providers while maintaining or improving quality of care. FTC staff offers no opinion about whether the DSO model is necessarily better than the traditional model for running a dental practice. To the extent, however, that some North Carolina dentists have found DSOs to be an efficient arrangement to help manage the non-clinical aspects of their practices, care should be taken not to impose unnecessary restrictions that would increase the costs associated with their attempts to focus on dental care, while turning over the non-clinical functions to people who specialize in those activities. When these restrictions act as barriers to new and

efficient entry, and thereby inhibit competition, consumers may face higher prices, decreased access, and fewer choices as a result.[42]

It is our understanding that most other states' dental statutes and administrative rules do not specifically address the DSO model. Like North Carolina, many states have a statutory definition of "dentistry" or the "practice of dentistry," which often includes an identified list of clinical acts that constitute the practice of dentistry. These states typically prohibit anyone other than licensed dentists from engaging in such practices and the licensing regime primarily addresses provider quality and care. Some states also prohibit a person, firm, partnership, corporation, or other entity from practicing dentistry under another person's license.[43] Even with these limitations on the practice of dentistry, DSOs operating in other states appear able to offer an array of commonly provided administrative and management services, even where they are prohibited from providing clinical services because they are unlicensed to do so. According to the CEO of one DSO, its business model emphasizes new entry and "focuses its entry and expansion efforts on markets in which dentists are in short supply."[44] Moreover, "[d]ental practices affiliated with DSOs accept commercial insurance at a significantly higher rate than practices unaffiliated with DSOs, resulting in discounted services and lower out-of-pocket expenses for commercially insured patients."[45]

In contrast, the proposed Bill will create a more restrictive regulatory environment for DSOs in North Carolina, which likely will undermine DSOs' ability and desire to negotiate contracts with dentists in North Carolina – even though the DSO business model could yield benefits for patients because it typically allows dentists to spend more time on patient care and less time on administrative tasks.[46] Given that the Board already oversees health and safety issues as part of the licensure regime that governs all dentists in the state, and given that DSOs focus solely on non-clinical aspects of dental practice, it does not appear that the Bill would enhance the Board's ability to ensure patient safety.

The proposed Bill may affect the operations of existing DSOs that are already doing business in the state, in addition to discouraging entry by new DSOs. The Bill would give the Board control over the timing of the DSO approval process and related disciplinary proceedings. We are concerned that the Board could exercise this control to block the operation of dental practices that are already utilizing DSOs, by delaying its review of management agreements.[47] The Board's recent action against an established dentist when he entered a management contract with a DSO, and the Board's consent agreement preventing that DSO from entering North Carolina for five years, provide strong evidence of the Board's hostility toward dentists' use of DSOs to help manage the non-clinical aspects of their practices.[48] It is our understanding that several DSOs have changed their entry plans, either not entering the North Carolina market or scaling back their entry plans, because of the Board's hostile attitude and actions against DSOs.[49]

The proposed Bill would give the Board expansive auditing rights over DSO operations. To the extent DSOs choose to stay in North Carolina and are permitted to do so, this auditing requirement could add to the costs borne by DSOs and dentists without enhancing patient care; those costs likely would be passed on to insurers and consumers in the form of higher prices for dental services.

Moreover, during the course of reviewing or auditing management contracts between dentists and DSOs, the Board would be permitted to collect competitively sensitive information. If the Board chose to disapprove a management contract and there were follow-on proceedings, it is very possible that such competitively sensitive information could be made public.[50] In some circumstances, sharing information among competitors may increase the likelihood of collusion or coordination on matters such as price or output.[51] If dentists in North Carolina were to gain access to information about their competitors, this too could lead to decreased competition and higher prices in the market for dental services in North Carolina.

V. CONCLUSION

Restrictions on how licensed professionals organize their business practices appear unnecessary to protect consumers, and this general principle appears to apply specifically to the provision of dental services. When licensed dentists choose to use DSOs to manage the non-clinical, back-office aspects of their practices, the dentists continue to control the clinical aspects of caring for patients, subject to the existing licensure framework that ensures safe dental practice. Therefore, and not surprisingly, we are unaware of any safety or quality issues arising from the use of DSOs.

Restrictions on the ability of dentists to run their practices by contracting out the management functions provided by DSOs may reduce competition and consumer choice by preventing the emergence and expansion of new, more efficient forms of professional practice. For these reasons, and in the absence of DSO-specific safety concerns, we urge the North Carolina legislature to consider the potential anticompetitive effects of H.B. 698 – including higher prices, reduced access, and decreased choices for consumers – and to reject H.B. 698 (as well as S.B. 655, the companion bill in the North Carolina Senate).

Respectfully submitted,

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Richard A. Feinstein, Director
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[1] This staff letter expresses the views of the Federal Trade Commission's Office of Policy Planning, Bureau of Competition, and Bureau of Economics. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has voted to authorize staff to submit these comments.

[2] We understand that identical legislation was introduced in the North Carolina Senate as S.B. 655; therefore, our comments would be applicable to both proposed Bills.

[3] Current North Carolina law prohibits unlicensed persons from performing certain clinical dental procedures as defined in the law, and also prohibits unlicensed persons from owning, managing, supervising, controlling, or conducting "any enterprise wherein one or more of the [clinical] acts or practices" are done. N.C. GEN. STAT. § 90-29 (b) (11) (clinical functions set forth in § 90-29 (b), subsections (1) through (10)), *available at* http://ncdentalboard.org/PDF/General%20Statutes8-10.pdf.

[4] Letter from the Hon. Stephen LaRoque, North Carolina House of Representatives, to Susan DeSanti, Director, Office of Policy Planning, Federal Trade Commission (undated) [hereinafter Letter from Rep. LaRoque].

[5] *Id. See also* H.B. 698, *available at* http://www ncga.state.nc.us/Sessions/2011/Bills/House/HTML/H698v1 html.

[6] See N.C. GEN. STAT. § 90-29 (b) (11), discussed *supra* at note 3.

[7] H.B. 698 at §90-40.2 (c)(2). We have been unable to find a clear articulation of the reasons for proposing this legislation, other than the Bill's general statement that it is "An Act To Require that Dentist Agreements With Management Companies Do Not Shift Control Of Clinical Patient Services Away From Licensed Dentists." As noted in footnote 3, *supra*, however, current law in North Carolina already appears to address this issue.

[8] In the Matter of Gary L Cameron, D.D.S., Before the North Carolina Board of Dental Examiners (Consent Order, Aug. 30, 2011) (noting Dr. Cameron received his license in Aug. 1977 (¶ 2), there were no prior Board disciplinary actions against Dr. Cameron in 34 years of practice (¶ 35), and "the Board did not receive any evidence of negligent patient care by Respondent or any evidence that non-licensed individuals conducted any patient care at" his dental clinic (¶ 34). *See also* discussion, *infra*, at footnotes 47 and 48 and accompanying text.

[9] Federal Trade Commission Act, 15 U.S.C. § 45.

[10] Standard Oil Co. v. Fed. Tr. Comm'n, 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[11] *See, e.g.*, In re North Carolina Board of Dental Examiners, FTC Dkt. No. 9343, Opinion and Order of the Commission (Dec. 7, 2011), *available at*: http://www ftc.gov/os/adjpro/d9343/111207ncdentalopinion.pdf (challenging the North Carolina Board of Dental Examiners' efforts to prevent non-dentists from providing teeth whitening services); In re South Carolina State Board of Dentistry, 138 F.T.C. 229, 233-40 (2004), *available at* http://www.ftc.gov/os/adjpro/d9311/040728commissionopinion.pdf (FTC opinion on an interlocutory appeal in a case challenging the South Carolina Dental Board's adoption of a requirement, which the state legislature had eliminated, that a dentist examine all school children receiving care from a dental hygienist); In re South Carolina State Board of Dentistry, FTC Dkt. No. 9311, Decision and Order (2007), *available at* http://www.ftc.gov/os/adjpro/d9311/070911decision.pdf (consent agreement settling charges concerning the requirement for examination by a dentist for certain preventative dental services provided by a dental hygienist in a school); FTC Staff Comment Before the Maine Board of Dental Examiners Concerning Proposed Rules to Allow Independent Practice Dental Hygienists to Take X-Rays in Underserved Areas (Nov. 2011), *available at* http://ftc.gov/os/2011/11/111125mainedental.pdf; FTC Staff Comment To the Louisiana State Board of Dentistry Concerning Proposed Modifications to Louisiana's Administrative Rules on the Practice of Portable and Mobile Dentistry (Dec. 2009), *available at* http://www.ftc.gov/os/2009/12/091224commentladentistry.pdf; FTC Staff Comments Before the Louisiana House of Representatives Concerning Louisiana House Bill 687 on the Practice of

In-School Dentistry (May 1 & May 22, 2009), *available at* http://www.ftc.gov/os/2009/05/V090009louisianahb687amendment.pdf and http://www.ftc.gov/os/2009/05/V090009louisianadentistry.pdf; *see generally* FTC, Advocacy Filings by Subject, Dentistry, *available at* http://ftc.gov/opp/advocacy_subject.shtm#detg.

[12] *See, e.g.*, Oklahoma State Board of Veterinary Medical Examiners, 113 F.T.C. 138 (Jan. 31, 1990) (consent order against the Oklahoma State Board of Veterinary Medical Examiners for allegedly restricting veterinarians from being partners with, employed by, or otherwise associated with non-veterinarians or veterinarians licensed in other states); R. Bond et al., FTC BUREAU OF ECONOMICS STAFF REPORT ,THE EFFECTS OF RESTRICTIONS ON ADVERTISING AND COMMERCIAL PRACTICE IN THE PROFESSIONS: THE CASE OF OPTOMETRY (1980); STAFF REPORT TO THE FEDERAL TRADE COMMISSION, ADVERTISING OF VETERINARY GOODS AND SERVICES (1978).

[13] FTC and staff advocacy may comprise letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. *See, e.g.,* FTC Staff Comment to the Honorable Patricia Todd of the Alabama House of Representatives Concerning Alabama House Bill 156 Allowing Veterinarians to Work as Employees of 501(C)(3)Nonprofit Spay and Neuter Clinics (April 2012), *available at* http://www.ftc.gov/os/2012/04/120426alabamaletter.pdf (commenting favorably on the bill and discussing the harm that can result from restrictions on the business practices of state-licensed professionals); FTC Staff Comment to the Honorable John T. Bragg Concerning Tennessee H.B. 2542 Allowing Veterinarians to be Employed by Non-Veterinarian Corporations (Feb. 1996), *available at* http://www ftc.gov/be/v960005.shtm (commenting favorably on a bill to eliminate restrictions on veterinarians being employed by non-veterinarians); FTC Staff Comment Before the Texas Sunset Advisory Committee Concerning its Review of Boards that Regulate Health Professions (Aug. 1992), *available at* http://www ftc.gov/be/healthcare/docs/AF%2017.pdf (comments on review of legislation governing various professional boards, including dentists, veterinarians, and physicians, noting "studies have found little relationship between restrictions on professionals' business practices and the quality of care provided").

[14] American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd* 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided court*, 455 U.S. 676 (1982).

[15] American Medical Ass'n, 94 F.T.C. at 1012-13, 1015-18.

[16] DEP'T OF HEALTH & HUMAN SERVS., ORAL HEALTH IN AMERICA: A REPORT OF THE SURGEON GENERAL 1 (2000), *available at* http://www.nidcr nih.gov/DataStatistics/SurgeonGeneral/ [hereinafter 2000 SURGEON GENERAL REPORT], cited in *Surgeon General's Perspectives*, 125 PUBLIC HEALTH REP. 158 (Mar.-Apr. 2010), *available at* http://www.publichealthreports.org/issueopen.cfm?articleID=2369 (53 million people in the U.S. live with untreated tooth decay, and the problem disproportionately affects disadvantaged communities).

[17] 2000 SURGEON GENERAL REPORT, *supra* note 16, at vii (Foreward), 2-3, 6. Because low income and poverty can prevent some individuals from obtaining needed dental care, participation by dentists in Medicaid dental programs is important to improving access to care. *See generally* Mark W. Casey, Dental Director, Division of Medical Assistance, NC Medicaid Dental Program, Presentation at slides 19-20 (April 26, 2011), *available at* http://www.nciom.org/wp-content/uploads/2010/12/Casey_4-26-11.pdf (noting fewer than 50% of NC dentists did any Medicaid billing and fewer than 25% did $10,000 or more in Medicaid billing); NORTH CAROLINA INSTITUTE OF MEDICINE, 2005 NORTH CAROLINA ORAL HEALTH SUMMIT ACCESS TO DENTAL CARE: SUMMIT PROCEEDINGS 4, Tables 1 and 2 (Oct. 2005), *available at* http://www nciom.org/wp-content/uploads/NCIOM/projects/dental/2005dentalupdate.pdf [hereinafter NCIOM 2005 ORAL HEALTH SUMMIT] (noting from 2001 through 2004 fewer than 50% of NC dentists participated in Medicaid, and only 20-25% of NC dentists treated Medicaid patients on a regular basis).

[18] CENTERS FOR DISEASE CONTROL, NATIONAL CENTER FOR CHRONIC DISEASE PREVENTION AND HEALTH PROMOTION, DIVISION OF ORAL HEALTH, ORAL HEALTH: PREVENTING CAVITIES, GUM DISEASE, TOOTH LOSS, AND ORAL CANCERS, AT A GLANCE (2011), *available at* http://www.cdc.gov/chronicdisease/resources/publications/aag/pdf/2011/Oral-Health-AAG-PDF-508.pdf.

[19] *See* INSTITUTE OF MEDICINE, REPORT BRIEF, ADVANCING ORAL HEALTH IN AMERICA (April 2011), *available at* http://www.iom.edu/~/media/Files/Report%20Files/2011/Advancing-Oral-Health-in-America/Advancing%20Oral%20Health%202011%20Report%20Brief.pdf.

[20] PEW CHILDREN'S DENTAL CAMPAIGN, A COSTLY DESTINATION: HOSPITAL CARE MEANS STATES PAY DEARLY, at 1 (Feb. 2012) , *available at* http://www.pewstates.org/uploadedFiles/PCS_Assets/2012/A%20Costly%20Dental%20Destination(1).pdf.

[21] *Id*. at 5.

[22] A REPORT ON HEALTH CARE RESOURCES IN NORTH CAROLINA, NORTH CAROLINA HEALTH PROFESSIONS 2010 DATA BOOK 5, 16 (released Aug. 2011, data effective as of Oct. 2010), *available at* http://www.shepscenter.unc.edu/hp/publications/2010_HPDS_DataBook.pdf [hereinafter NORTH CAROLINA 2010 DATA BOOK].

[23] NATIONAL CENTER FOR HEALTH STATISTICS. HEALTH, UNITED STATES, 2010: WITH SPECIAL FEATURE ON DEATH AND DYING 349 (2011), *available at* http://www.cdc.gov/nchs/data/hus/hus10.pdf , Table 109, *available at* http://www.cdc.gov/nchs/data/hus/2010/109.pdf.

[24] U.S. DEPT. OF HEALTH & HUMAN SERVS., HEALTH RESOURCE & SERVS. ADMIN. (updated as of May 10, 2012), *available at* http://hpsafind.hrsa.gov/HPSASearch.aspx. *See also* 2005 NCIOM 2005 ORAL HEALTH SUMMIT, *supra* note 17, at 15 (in 2005, 79 of 100 NC counties were designated as Dental Health Professional Shortage Areas, indicating these shortages have persisted over time), *available at* http://www.nciom.org/wp-content/uploads/NCIOM/projects/dental/2005dentalupdate.pdf.

[25] NORTH CAROLINA 2010 DATA BOOK, *supra* note 22, at 16.

[26] Letter from Rep. LaRoque, *supra* note 4.

[27] Dr. Clifton Cameron, *Op-ed: Legislation would restrict entry in the state*, FayObserver.com (June 16, 2011), *available at* http://www.fayobserver.com/articles/2011/06/16/1101641.

[28] *Id*. *See also* DGPA History, *available at* http://www.dgpaonline.org/history.aspx. The Dental Group Practice Association ("DGPA") is a non-profit organization representing DSOs. DGPA materials note that DSOs provide business management and support services to more than 3,500 dental practices in 46 states, plus Canada, Australia and New Zealand, with more than 6,500 affiliated/owner dentists. The DGPA Student Brochure, available at http://www.dgpaonline.org/docs/DGPA-Student-Brochure.pdf, describes some of the services DSOs can provide to dentists, including:

> **Centralized practice support** – Administrative experts handle all non-clinical needs of the practice, from marketing plans, accounts receivable/payable, and tax reports, to site selection/lease negotiation and more.
> **Human Resources support** – Tailored HR systems provide staffing, benefit programs and oversight, freeing up dentists to see more patients and/or improve the quality of life.
> **Access to capital for capital investments** – Dentists are provided access to funds necessary to grow and support their dental practices, allowing them to offer convenient, quality patient care.
> **Professional marketing** – Professional, tailored campaigns and tools help dentists attract more patients at lower costs.
> **Economies of scale** – Greater buying power enables dentists to provide services that patients value and can afford.
> **Modern facilities with the latest technology** – Purchasing leverage, available capital, and continuous R&D help put state-of-the-art tools and products at the dentists' fingertips.
> **Quality assurance systems** – With their DSOs, dentists develop programs that ensure consistent excellence patient confidence, quality of care, and exceptional team performance.
> **Ongoing education and training** – Dentists are assured of staying ahead of trends, technologies, and practice management tools and techniques.

[29] H.B. 698 at §90-40.2 (c) (2).

[30] *Id.* at §90-40.2 (d) and (e). For example, §90-40.2 (d) states in part: "No management arrangement shall provide for or permit any provision, which alone or in combination with others, (i) has a potential negative impact on patient care, [or] (ii) affects the provision of dental services, the professional decision making of the dentist, or other personnel of the dentist or professional entity." Both provisions are so vague as to provide no meaningful guidance to the Board, dentists, or DSOs. Provisions in §90-40.2 (e) enumerate 23 items that no management agreement can provide or permit, including, among many others, items related to leasing space, payments to suppliers, and dental practice hours; these provisions are vague and, depending upon interpretation, could undermine the very foundation of DSO agreements with dentists. Moreover, §90-40.2 (e) notes that this list is not exhaustive, which leaves the Board extraordinary discretion to prohibit virtually any provision in a DSO contract.

[31] *Id.* at §90-40.2 (i).

[32] *Id.* at §90-40.2 (k).

[33] *Id.* at §90-40.2 (s).

[34] *Id*.

[35] *Id*.

[36] *Id.* at §90-40.2 (l).

[37] *See* Affidavit of Michael Kahan, former Interim CEO of DentalCare Partners, Inc. (Sept. 22, 2011) [hereinafter Kahan Affidavit], ¶¶ 7-9 (describing one DSO's plans to develop 33 new-entry practices in NC between 2009 and 2014, but noting the DSO has reevaluated this plan because the Board "has become increasingly hostile to the DSO business model;" the "Board has taken aggressive disciplinary action against dentists affiliated with [its] company" and "regularly rejected proposed management agreements similar to those that [their] affiliated dentists have operated under for more than a decade in North Carolina"). *See also* Donna Domino, DrBicuspid.com, *NC bill would give dental board authority over contracts*, (July 5, 2011), *available at* http://www.drbicuspid.com/index.aspx?sec=sup&sub=pmt&pag=dis&ItemID=308033. This article quoted a NC State Senator who is a dentist as saying, "I'm totally for legislation that will preserve the sanctity of the doctor/patient relationship that's consistent with dental ethics, but I really struggle with the dental board becoming involved with the business aspects of a dental practice;" the same dentist described as "overreaching" the requirement that the Board must give its "permission" to any dentist entering into a management contract.

[38] *See* Goldfarb v. Virginia State Bar, 421 U.S. 773, 787 (1975).

[39] *Cf.* FTC. v. Ind. Fed'n of Dentists, 476 U.S. 447, 459 (1986) ("Absent some countervailing procompetitive virtue," an impediment to "the ordinary give and take of the market place . . . cannot be sustained under the Rule of Reason.") (internal quotations and citations omitted).

[40] CAROLYN COX & SUSAN FOSTER, FEDERAL TRADE COMMISSION, BUREAU OF ECONOMICS, THE COSTS AND BENEFITS OF OCCUPATIONAL REGULATION 25 (1990), *available at* http://www.ftc.gov/be/consumerbehavior/docs/reports/CoxFoster90.pdf (emphasis in original) [hereinafter COX & FOSTER, OCCUPATIONAL REGULATION]. This report, a review of economic studies of licensing, found licensing frequently increases prices and imposes substantial costs, but generally does not appear to increase the quality of service, especially with respect to restrictive regulation of business practices. The report recommends careful weighing of likely costs against prospective benefits. *See generally id.* at 25-27, 29-36 for a discussion of effects from restrictions on the business practices of licensed professionals.

[41] *See* American Medical Ass'n, 94 F.T.C. 701 (1979), *aff'd* 638 F.2d 443 (2d Cir. 1980), *aff'd mem. by an equally divided court*, 455 U.S. 676 (1982).

[42] *See* Deborah Haas-Wilson, *Strategic Regulatory Entry Deterrence: An Empirical Test in the Ophthalmic Market*, 8 J. HEALTH ECON. 339 (1989) (econometric study of optical goods markets concludes that "form of practice" restrictions have been used to deter entry and maintain higher prices); COX & FOSTER, OCCUPATIONAL REGULATION, *supra* note 40, at 25-27, 29-36 (discussing higher prices associated with restrictions on business practices); R. BOND ET AL., THE EFFECTS OF RESTRICTIONS ON ADVERTISING AND COMMERCIAL PRACTICE IN THE PROFESSIONS: THE CASE OF OPTOMETRY, FTC BUREAU OF ECONOMICS STAFF REPORT (1980) (restrictions on advertising and commercial practice may increase price by as much as 33%).

[43] *See, e.g.*, Georgia, O.C.G.A. § 43-11-1; O.C.G.A. § 43-11-50.7; O.C.G.A. § 43-11-51; South Carolina, SC Code of Laws §§ 40-15-70, -135; Tennessee, T.C.A. §§ 63-5-108, -121; and Virginia, V.C. §§ 54.1-2700, -2711.

[44] Affidavit of Robert Fontana, CEO of Aspen Dental Management, Inc. (Sept. 16, 2011) [hereinafter Fontana Affidavit], ¶¶ 5-6. *See also* Kahan Affidavit, *supra* note 37, at ¶ 2 (noting "DentalCare Partners' growth model is generally predicated on *de novo* entry").

[45] Fontana Affidavit, *supra* note 44, at ¶ 9.

[46] *See, e.g.,* Dr. Clifton Cameron, *Op-ed: Legislation would restrict entry in the state*, FayObserver.com (June 16, 2011), *available at* http://www fayobserver.com/articles/2011/06/16/1101641 (discussing how DSOs help him spend more time with his patients and less time on administrative tasks); Fontana Affidavit, *supra* note 43, at ¶ 3 (the "DSO model promotes efficient, high-output dentistry by relieving affiliated dentists of administrative burdens associated with operating a dental practice," thereby giving the dentist more time to devote to patient care).

[47] *See North Carolina State Board of Dental Examiners v. Heartland Dental Care, Inc.*, 11 CVS 2343 (N.C., Randolph County General Court of Justice, Superior Court Division, Heartland's Answer to Complaint for Permanent Injunction, ¶ 1. According to Heartland's Answer, although the Board's regulations required only review and not prior approval of DSO-dentist management agreements, Heartland and Dr. Gary Cameron submitted the management agreement to the Board on Feb. 2, 2010, and after hearing nothing from the Board, signed the contract on March 31, 2010. It was not until May 10, 2010, that the Board contacted the parties and alleged that 18 aspects of the agreement violated the Board's rules with respect to management agreements.

[48] *See* In the Matter of Gary L Cameron, D.D.S., Before the North Carolina Board of Dental Examiners (Consent Order, Aug. 30, 2011); *North Carolina State Board of Dental Examiners v. Heartland Dental Care, Inc.*, 11 CVS 2343 (N.C., Randolph County General Court of Justice, Superior Court Division, Sept. 6, 2011) (Consent Order Granting Permanent Injunction).

[49] *See, e.g.*, Kahan Affidavit, *supra* note 37, at ¶¶ 9-11 (noting the Board's "clear animus towards DSO providers and their affiliated dentists" has forced the company "to re-evaluate its growth strategy in North Carolina" and curtail its expansion plans; the company "has opted to continue to make lease payments on an empty building in North Carolina rather than undertake the financial risk of investing in the development of a new serviced-practice," and "[b]ut for the Dental Board's interference, [the company] would view North Carolina as a market rich in opportunity for growth and expansion"); Fontana Affidavit, *supra* note 44, at ¶¶ 11-13 (noting the North Carolina Dental Board "is generally hostile to the DSO business model" and "helping doctors establish new dental practices in North Carolina" would not be in the best interests of his company or the dentists with whom they would affiliate).

[50] H.B. 698 at §90-40.2 (l).

[51] FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, GUIDELINES FOR COLLABORATIONS AMONG COMPETITORS §3.31(b) (discussing potential harms to competition when competitors exchange or disclose sensitive business information). *See also* U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE, Statement 6 (Aug. 1996), *available at* http://www ftc. gov/bc/healthcare/industryguide/policy/hlth3s.pdf (same); Letter from FTC Staff to Sen. James L. Seward, New York Senate (Mar. 31, 2009), *available at* http://www.ftc.gov/os/2009/04/V090006newyorkpbm.pdf (disclosure of

sensitive business data in one market segment may chill competition in multiple market segments); U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N, HORIZONTAL MERGER GUIDELINES §7 (2010), *available at* http://ftc.gov/os/2010/08/100819hmg.pdf (describing anticompetitive effects of coordination among rivals, noting coordinated interaction "can blunt a firm's incentive to offer customers better deals by undercutting the extent to which such a move would win business away from rivals" and "also can enhance a firm's incentive to raise prices by assuaging the fear that such a move would lose customers to rivals").