No. 13-534

In the Supreme Court of the United States

NORTH CAROLINA STATE BOARD OF DENTAL EXAMINERS, PETITIONER

v.

FEDERAL TRADE COMMISSION

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF FOR THE ASSOCIATION OF DENTAL SUPPORT ORGANIZATIONS AS AMICUS CURIAE IN SUPPORT OF RESPONDENT

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INTEREST OF AMICUS[1]

The Association of Dental Support Organizations (Association or ADSO) is a nonprofit industry association, representing over thirty dental support organizations (DSOs). DSOs provide essential services to thousands of dentists across the United States. By delivering non-clinical services such as human resources, bookkeeping, billing, and accounting, DSOs allow affili-

[1] The parties have consented to the filing of amicus curiae briefs in support of either party or of neither party in letters on file with the Clerk. No counsel for any party authored this brief in whole or in part, and no person or entity, other than amicus curiae or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief.

ated practitioners to focus on patient care. The Association's members play a vital role in supporting the delivery of affordable, accessible, and high-quality dental care to patients, including patients in areas underserved by high-cost traditional dental practices.

This case presents issues relating to the anticompetitive behavior of licensing boards dominated by self-interested market participants and how that anticompetitive behavior can adversely affect public access to affordable dental care. ADSO is acutely aware of the anticompetitive risks inherent in allowing self-interested market participants to regulate their own field of practice. Acting on the incentive to restrict competition, state dental boards have in recent years actively sought to limit or exclude DSOs from entering their markets and have undertaken a variety of restrictive activities that prevent DSOs from operating efficiently and effectively. Indeed, ADSO members have direct experience with the North Carolina Board of Dental Examiners, which has harmed competition by asserting an overly expansive definition of the practice of dentistry. Such anticompetitive practices by state dental boards have resulted in higher costs to patients and less dental care to underserved communities, to the detriment of dental health in this country.

INTRODUCTION AND SUMMARY

This case began with the North Carolina State Board of Dental Examiners (Board) sending dozens of cease-and-desist letters to non-dentists in an effort to drive non-dentist competitors out of the North Carolina market for teeth whitening services. The Board is composed almost entirely of practicing dentists who

have a financial stake in preventing competition for teeth whitening services. Yet the Board's self-serving policy choices were not subject to review by independent state officials acting out of concern for public health and safety. Indeed, many types of anticompetitive acts by market-participant dominated boards similar to those of the Board at issue here would never be subject to any independent review, much less effective review of the substance of the board's policy choices. In such circumstances, there is no basis for immunizing the Board's actions from scrutiny under the federal antitrust laws.

I. The doctrine of state-action immunity is limited to policies clearly articulated by the state itself and does not permit the state to immunize unsupervised anticompetitive action by a group of market participants simply by denominating them a state agency. See *Parker* v. *Brown*, 317 U.S. 341, 352 (1943). Instead, private market participants claiming state-action immunity must show that they are (1) acting in accordance with a clearly articulated state policy and (2) "actively supervised" by independent state officials. *Cal. Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (*Midcal*). The active supervision prong of the *Midcal* test is designed to guard against the "real danger" that private parties claiming the mantle of state authority are in fact engaging in anticompetitive conduct "to further [their] own interests, rather than the governmental interests of the State." *Town of Hallie* v. *City of Eau Claire*, 471 U.S. 34, 47 (1985).

The state-action immunity doctrine, a construction of the Sherman Act, *Parker*, 317 U.S. at 351, represents

a careful balance between the fundamental national value of free market competition and principles of federalism. Requiring private market participants to be actively supervised by independent state officials appropriately respects state sovereignty while simultaneously guarding against the tangible risk that market participants, exercising coercive state power, will act in their own self-interest and to the detriment of the public at large. The cease-and-desist letters in this case—sent by a board comprised almost entirely of practicing dentists who stand to profit from performing teeth whitening services at high cost—exemplify the "real danger" that the active supervision prong is designed to guard against.

II. The risk that market participants acting as state regulatory boards will use their authority to further their own self-interest, and thereby deprive the public of the benefits of competition, is apparent. Incumbents have strong economic incentives to protect the status quo and perpetuate existing business models, wholly apart from concerns about delivering high-quality products and services. By suppressing competition that results in higher quality, higher output, increased efficiency, and reduced costs, unsupervised boards comprised of market participants reduce consumer access, including access to health care.

ADSO members have experienced this risk firsthand in the market for dental services. DSOs provide dentists, many of whom lack business training, with critical business support that allows affiliated dentists to focus their time on patient care instead of paperwork and other administrative tasks. The resulting increase in available clinical dentistry improves access

to care for patients in need. Moreover, by increasing efficiency, and reducing costs, DSO-affiliated dentists can reach underserved populations, such as by increasing the number of dentists who accept insurance. Given the lack of access to dental care in states like North Carolina, improved access is a critical public health issue. Yet, the North Carolina Board has fought entry of DSO-affiliated dental practices because they threaten the established solo practitioner model that serves the interests of established market participants. The North Carolina Board's actions tellingly mirror those of the American Medical Association and state affiliates that, forty years ago, employed medical ethics guidelines in an effort to stifle competition from new business models like Health Maintenance Organizations and hospital affiliated practices.

Other examples of market participants implementing anticompetitive policies under the guise of state regulatory authority abound, spanning numerous industries and professions.

Boards have expansive powers, and market participant members of those boards can use them to serve narrow self interests. Many actions by the boards are not subject to any judicial review at all, and even when they are, the judiciary is likely to defer to the boards' policy choices. There is no guarantee, in the absence of an active state supervision requirement, that the policy choices of a state board dominated by market participants will reflect the public policy choices of the state.

ARGUMENT

I. Market Participants Cannot Claim State-Action Immunity For Anticompetitive Conduct Not Actively Supervised By The State

State-action antitrust immunity is generally "'disfavored'" in light of the "fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws." *FTC* v. *Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1010 (2013) (quoting *FTC* v. *Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992)). As a result, private market participants who engage in anticompetitive conduct are immune from federal antitrust liability only if they satisfy the "rigorous" *Midcal* test, requiring both action in accordance with a clearly articulated state policy and active state supervision. *Patrick* v. *Burget*, 486 U.S. 94, 100 (1988) (citing *Cal. Retail Liquor Dealers Ass'n* v. *Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980) (*Midcal*)). Market participants must make this heightened showing because of the "real danger" that they will engage in anticompetitive behavior to "further [their] own interests, rather than the governmental interests of the State." *Town of Hallie* v. *City of Eau Claire*, 471 U.S. 34, 47 (1985).

The Board's formalistic approach, which turns exclusively on the market participants' designation as a state agency, would upset this balance. By eliminating the active supervision requirement, the Board proposes to eviscerate the protection that ensures that market participants clothed with state authority are using that

power to further the state's interests, rather than their own.

A. This Court Has Frequently Held That State Agencies Comprised Of Market Participants Enjoy Antitrust Immunity Only If They Are Actively Supervised By The State

The state-action doctrine construes the Sherman Act not to reach conduct of the States themselves. *Parker* v. *Brown*, 317 U.S. 341, 351 (1943). At the same time, "a state does not give immunity to those who violate the Sherman Act by authorizing them to violate it, or by declaring that their action is lawful." *Ibid.* Thus, this Court has long required states to actively supervise market participants if those market participants are to receive state-action immunity. The active supervision requirement has been applied as well to private market actors who were designated a state agency and exercised state regulatory authority. See, *e.g.*, *Goldfarb* v. *Virginia State Bar*, 421 U.S. 773, 790 (1975); *Midcal*, 445 U.S. at 105-106; *Patrick*, 486 U.S. at 100-105; *Ticor*, 504 U.S. at 635-637.

In *Goldfarb* v. *Virginia State Bar*, this Court concluded that the Virginia State Bar was not entitled to federal antitrust immunity even though it was undisputedly "a state agency by law." 421 U.S. at 790. The State Bar had established a minimum fee schedule for certain legal services. *Id.* at 788-792. This Court stressed that although "the State Bar is a state agency for some limited purposes," that fact alone "does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members" when there is "no indication * * * that the Virginia Su-

preme Court approves" the Bar's anticompetitive actions. *Id.* at 791. Because the State Bar was comprised of market participants acting in their own self-interest, without supervision from the Virginia Supreme Court, it did not enjoy state-action immunity. See *ibid.* As the Court noted, the State Bar had "voluntarily joined in what is essentially a private anticompetitive activity, and in that posture cannot claim it is beyond the reach of" federal antitrust law. *Id.* at 792. *Goldfarb* thus demonstrates that a state agency is not automatically entitled to state-action immunity when it is comprised of market participants. See *id.* at 790-792; see also *City of Lafayette* v. *Louisiana Power & Light Co.*, 435 U.S. 389, 410 (1978) (plurality opinion) ("*Goldfarb* therefore made it clear that, for purposes of the *Parker* doctrine not every act of a state agency is that of the State as sovereign.").

In cases where state agencies have been granted state-action immunity, the Court has done so after finding active state supervision. In *Bates* v. *State Bar of Arizona*, 433 U.S. 350 (1977), for example, the Court held that the Arizona State Bar's enforcement of lawyer fee advertising rules was immune from federal antitrust liability after finding that the disciplinary rules "reflect[ed] a clear articulation of the State's policy with regard to professional behavior," *and* that those rules were "subject to pointed re-examination by the policy maker—the Arizona Supreme Court—in enforcement proceedings." *Id.* at 362. Similarly, in *Southern Motor Carriers Rate Conference, Inc.* v. *United States*, the Court recognized state-action immunity for state rate bureaus after observing that "the State Public Service Commissions actively supervise[d]

the collective ratemaking activities of the rate bureaus." 471 U.S. 48, 62 (1985). Active state supervision, or lack thereof, is the common thread that explains the Court's decisions whether state agencies composed of market participants will be afforded state-action immunity for anticompetitive conduct that affects their own interests.

B. State-Action Immunity Is Designed To Ensure That State Bodies Act To Further The Public, Rather Than Private, Interest

The principles animating the state-action immunity doctrine demonstrate why a state regulatory board comprised of market participants is subject to the active supervision requirement. The state-action doctrine construes the Sherman Act not to reach certain otherwise illegal conduct out of respect for state sovereignty. See *Parker*, 317 U.S. at 352 (granting antitrust immunity because the state, "as sovereign, imposed the restraint as an act of government"); see also *Phoebe Putney*, 133 S. Ct. at 1010 (state-action immunity applies "only when it is clear that the challenged anticompetitive conduct is undertaken pursuant to a regulatory scheme that 'is the State's own'" (quoting *Ticor*, 504 U.S. at 635)). The doctrine does not simply allow the state to "cast[] a 'gauzy cloak of state involvement' over what is essentially private anticompetitive conduct." *Southern Motor Carriers*, 471 U.S. at 57 (quoting *Midcal*, 445 U.S. at 106).

The active supervision prong of the *Midcal* test thus serves the critical function of ensuring that anticompetitive policies will further state regulatory interests, as opposed to private self-interest. See *Patrick*,

486 U.S. at 100-101 ("[T]he active supervision requirement mandates that the State exercise ultimate control over the challenged anticompetitive conduct."). As this Court explained in *Ticor*, the purpose of the active supervision prong is "to determine whether the State has exercised sufficient independent judgment and control so that the details of the [anticompetitive policy] have been established as a product of deliberate state intervention." 504 U.S. at 634. If the anticompetitive conduct is not truly that of the state, the Sherman Act remains fully applicable. See *Southern Motor Carriers*, 471 U.S. at 61 (explaining that the state-action doctrine "represents an attempt to resolve conflicts that may arise between principles of federalism and the goal of the antitrust laws, unfettered competition in the marketplace").

The danger that market participants will use state authority to further their own self-interest requires that they be afforded immunity from federal antitrust laws only if active supervision by independent state officials ensures that their actions are the "product of deliberate state intervention." *Ticor*, 504 U.S. at 634. With good reason, this Court has recognized that market participants are "presumed to be acting primarily" in their own interests. *Town of Hallie*, 471 U.S. at 45. That risk is not diminished, but indeed increases, when the state grants a group of market participants regulatory authority. Without active state supervision, there can be no "realistic assurance" that the anticompetitive conduct of a state agency composed of market participants "promotes state policy, rather than merely the party's individual interests." *Patrick*, 486 U.S. at 101; see also *Town of Hallie*, 471 U.S. at 47 ("Where a pri-

vate party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State."). This is why the active supervision requirement itself is not satisfied merely by ensuring fidelity to process but requires some element of substantive review. See *Patrick*, 486 U.S. at 102 ("This statutory scheme does not establish a state program of active supervision over peer-review decisions. The Health Division's statutory authority over peer review relates only to a hospital's procedures; that authority does not encompass the actual decisions made by hospital peer-review committees." (footnote omitted)). Indeed, only when the state has "examine[d] individual private conduct, pursuant to [a] regulatory regime, to ensure that it comports with the stated criterion * * * can the underlying conduct accurately be deemed that of the state itself, and political responsibility for the conduct fairly be placed with the state." FTC, *Report of the State Action Task Force* 54 (2003), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/report-state-action-task-force/stateactionreport.pdf.

The Board's attempt to draw an analogy between itself and municipalities or state agencies that are not comprised of market participants is misplaced. Those state entities do not present the same institutional risks as a body dominated by private market participants. Municipalities and sub-state governmental entities not composed of market participants must show that they are acting in accordance with a clearly articulated state policy to displace competition. *Phoebe Putney*, 133 S. Ct. at 1010-1011 (state hospital authority); *Town of Hallie*, 471 U.S. at 46-47 (municipalities). But

they need not satisfy the active state supervision prong because they are, by their nature, "likely to be exposed to public scrutiny" and their officials are likely to be "checked to some degree through the electoral process." *Town of Hallie*, 471 U.S. at 45 n.9. Their "position in the public eye" provides independent "protection against antitrust abuses." *Ibid.* There are no such checks against "antitrust abuses" by the Board.

The Board's invocation of federalism interests rings hollow for similar reasons. The state-action doctrine, like principles of federalism generally, "serves to assign political responsibility, not to obscure it." *Ticor*, 504 U.S. at 636. Only "real compliance with both parts of the *Midcal* test will serve to make clear that the State is responsible for the [restraint] it has sanctioned and undertaken to control." *Ibid.* A state may choose to displace the federal policy in favor of market competition, but it must do so in a fashion that ensures transparency and accountability by those who are responsible to the public at large, not by simply cloaking a group of private market participants with the mantle of state authority. Simply designating a group of private market participants a state agency neither protects against their abuse of authority to serve private interests nor provides assurance that the state's elected leaders will be held accountable for its policies.

II. If Unsupervised, State Bodies Like The Board Can Use Their Considerable Power To Further Private Financial Interests To The Detriment Of The Public Health

The risk that state regulatory boards dominated by market participants will use their state-granted author-

ity to further their own self-interest—to the detriment of the public—is clear and concrete. ADSO members have experienced such anticompetitive conduct firsthand in the market for dental support services. But dentistry is hardly unique. Examples of market participants engaging in self-serving anticompetitive conduct in the name of the state span numerous professions. Market participants have strong economic incentives unrelated to public health to protect the status quo, perpetuate existing business practices, and exclude lower cost competition. There are ample historical examples of such anticompetitive conduct by market incumbents in the name of consumer welfare, such as early attempts by the American Medical Association (AMA) to exclude HMOs in the name of medical ethics. State boards dominated by market participants, like the North Carolina Dental Board, exert considerable power and regulate a vast array of industries, and market participants acting without active state supervision have been able to use their expansive regulatory powers improperly to suppress competition. By restricting a more efficient model for the delivery of administrative dental support services, state dental boards like North Carolina's would effectively force dentists to complete the various administrative support tasks in their practices personally, outsource the administrative tasks to several less-efficient vendors instead of a single integrated DSO, or some combination thereof. This type of board action artificially limits the supply of dental services, which disproportionately impacts access to care for the most underserved populations.

A. Market Participant Board Members Have Strong Incentives Unrelated To Professional Quality To Protect Existing Business Models

Although the Board and its amici wrap themselves in the mantle of maintaining professional standards and protecting public health, the reality is far more complicated. Market participant board members, no less than other market incumbents, have strong financial incentives to preserve existing economic models and to erect entry barriers to disruptive competition. Although their anticompetitive efforts are frequently undertaken in the name of professional ethics or public health, the effect is to suppress new, more efficient ways of supporting and providing health care more cost effectively and to a broader population. Cf. *Nat'l Soc'y of Prof'l Eng'rs* v. *United States*, 435 U.S. 679, 694-695 (1978) (justification for competitive bidding ban agreed to by rivals "on the basis of the potential threat that competition poses to the public safety and the ethics of its profession is nothing less than a frontal assault on the basic policy of the Sherman Act"). Tellingly, many of the most prevalent and successful models for practicing medicine today were actively suppressed by physician organizations for decades under the banner of medical ethics. Hostility to non-traditional business models continues today in the dental profession on the part of the North Carolina and other state dental boards.

1. *There is a long history of market incumbents erecting barriers to new business models in the name of ethics*

As the American Dental Association (ADA) has recognized, in dentistry as in other medical fields, there are a wide variety of economic models under which health care can be provided. Albert Guay et al., *A Proposed Classification of Dental Group Practices*, Health Policy Inst. Research Brief, Am. Dental Ass'n (Feb. 2014) (ADA Classifications), http://www.ada.org/~/media/ADA/Science%20and%20Research/HPI/Files/HPIBrief_0214_2.ashx. These include insurer-affiliated HMOs that employ medical professionals, non-profit organizations that serve disadvantaged populations, practitioners employed directly by governmental agencies, traditional practitioner-owned practices, and practitioners who affiliate with management service organizations (MSOs). *Ibid.* MSOs can undertake responsibility for "the major non-professional aspects of a practice," such as "personnel management, supplies and equipment purchases, office space, patient flow, office policies, practice analytics * * * , revenue management and marketing." *Ibid.*[2]

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[2] According to the ADSO website, DSOs provide a wide range of business support for dentists, including: "marketing plans, accounts receivable/payable, and tax reports," "site selection/lease negotiation," "staffing, benefit programs and oversight," "[a]ccess to capital for capital investments," "[p]rofessional marketing," and "[e]conomies of scale" for purchasing supplies. Ass'n of Dental Support Orgs., http://theadso.org/professional-resources/your-dental-career (last visited Aug. 5, 2014).

In a market free of protectionism, "no one form of dental practice will overwhelm the market" but rather "a variety of practices" would likely "evolve to satisfy the varied demands of patients and other stakeholders in the dental care system." ADA Classifications at 7. As the ADA acknowledged, the "key factors for successful innovation" should be that changes "enhance quality of care, efficiency of care delivery and availability of care for all who seek it." *Ibid.* Unfortunately, existing stakeholders' self-interest in protecting the status quo frequently causes them to oppose new economic models that can bring increased efficiency and access to care.

Many of the most successful models for providing medical services were once forbidden by the AMA as contrary to professional "ethics." In 1975, the FTC sued the AMA for, among other things, perpetuating a code of ethics designed "to preclude competition by group health plans, hospitals and other organizations not directly under the control of physicians." *In re Am. Med. Ass'n*, 94 F.T.C. 701, 980, 1016 (1979), aff'd sub nom. *Am. Med. Ass'n* v. *FTC*, 638 F.2d 443 (2d Cir. 1980), aff'd by equally divided court, 455 U.S. 676 (1982). In particular, the AMA had prohibited arrangements that denied patients "free choice of physicians" on the ground that "mutual benefit associations, so-called health and hospital associations, and other forms of contract practice" had given rise to a "destructive competition." *Id.* at 1012-1013 (internal quotations omitted).

The FTC found that the purpose and effect of the provision was "not solicitude for the rights of patients" but rather to "impair[] competition from alternative

providers in the medical service market by discouraging use of innovative arrangements that can deliver services at lower cost." *In re Am. Med. Ass'n*, 94 F.T.C. at 1015. Similarly, the AMA had adopted an ethical prohibition against methods of competition other than fee-for-service in an attempt to "preclude[] the use of salaries or other arrangements" by "hospitals [and] prepaid health plans," and similarly proscribed arrangements with non-physicians in an effort "to prevent physicians from associating with many HMOs or prepaid health care plans." *Id.* at 1016, 1018. Though these ethics rules had been adopted in the name of maintaining the quality of medical care, the FTC found that the AMA had "go[ne] far beyond anything that might be reasonably related to the goal of preventing use of improper medical procedures." *Id.* at 1012.[3]

2. *The Board's suppression of DSOs mirrors the AMA's earlier suppression of HMOs and other business models*

While the AMA may have abandoned its "anti-HMO" activities, *In re Am. Med. Ass'n*, 94 F.T.C. at 1017 n.67, that type of attitude continues to be prevalent among many state dental boards, including the North Carolina Board. The strong self-interest among existing market participant dentists to oppose new business arrangements is clear. Dentists have tradi-

[3] The issue on appeal that divided the appellate judges was not whether the AMA's ethics rules had been used to restrain competition, but whether the AMA had already abandoned its anticompetitive posture in light of this Court's *Goldfarb* decision. See *Am. Med. Ass'n* v. *FTC*, 638 F.2d 443, 454 (2d Cir. 1980) (Mansfield, J., dissenting), aff'd by equally divided court, 455 U.S. 676 (1982).

tionally practiced as solo practitioners. Many current dentists have a considerable part of their net worth (and expected retirement funds) tied up in their practice. Dentists in solo or small practices therefore have a strong incentive to retain the value of their practices so they can sell their practices to the next generation of dentists. Private dentists, acting together under color of state authority as state boards, have thus attempted to erect barriers to, and taken affirmative steps to suppress, economic models other than small practices, despite the success of those models in other medical fields. Indeed, whereas the AMA estimates that only 18% of medical doctors were practicing within a solo practice in 2012, among dentists more than 57% were still practicing in solo practices in 2012. See Carol K. Kane & David W. Emmons, *New Data On Physician Practice Arrangements: Private Practice Remains Strong Despite Shifts Toward Hospital Employment* 5, 9 (2013), http://www.nmms.org/sites/default/files/images/2013_9_23_ama_survey_prp-physician-practice-arrangements.pdf; ADA Classifications at 2.

In the absence of regulatory hostility, MSOs (or DSOs as they are referred to in the dental field) would offer considerable advantages to dentists engaged in private practice. As the FTC has noted, "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." Letter from Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission, to the Hon. Stephen LaRoque, North Carolina House of Representatives (FTC NC DSO Letter) 1 (May 25, 2012),

http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-letter-nc-representative-stephen-laroque-concerning-nc-house-bill-698-and-regulation/1205ncdental.pdf. Because dentists "learn[] little in dental school about running a business," many "look[] to outside companies to help finance the practice, manage billing, handle payroll, file insurance and execute other administrative tasks." *Id.* at 4 (internal quotation marks omitted).

Allowing dentists to "organize their practices in the way they find most efficient, consistent with quality care," benefits patients as well. FTC NC DSO Letter at 1. Because DSOs operate with greater efficiencies, competition from DSOs offers "the potential for lower prices, improved access to care, and greater choice." *Ibid.* Indeed, one dentist commented that his affiliation with a DSO "helped our dental practice operate so efficiently that we can charge lower rates and accept dental insurance from patients." *Id.* at 4. Finding a dentist, especially one who accepts insurance, can be a challenge, especially in North Carolina, where the number of dentists per capita is low and there are relatively few DSO-affiliated dentists (who accept insurance at significantly higher rates than others). See *id.* at 3 (North Carolina has "historically ranked near the bottom of the fifty states in terms of dentist-to population ratio"); *id.* at 6 (" 'dental practices affiliated with DSOs accept commercial insurance at a significantly higher rate than practices unaffiliated with DSOs' " (quoting Robert Fontana, Chief Executive Officer of Aspen Dental Management, Inc.)).

But the very benefits that DSO-affiliated practices can provide consumers, such as lower costs and better

insurance coverage, provide incentives for market participant members of the Board to suppress those arrangements. And, in fact, the FTC has noted "the Board's hostile attitude and actions against DSOs." FTC NC DSO Letter at 6.

The Board's attempt to suppress competition from DSO-affiliated dentists mirrors to a significant degree the AMA's efforts to combat HMO and hospital association contracts with doctors forty years ago. State dental boards, including North Carolina's, have used their regulatory authority to suppress DSO affiliation and preserve the existing solo or small practice model by advancing a broad definition of the "practice of dentistry" that includes many business-support services that DSOs provide. Many states, like North Carolina, define the "practice of dentistry" using vague, general terms, such as any person who "[o]wns, manages, supervises, controls, or conducts, either himself or by and through another person or other persons, any enterprise wherein" certain medical services are performed. N.C. Gen. Stat. § 90-29(b)(11).[4] Seizing on ambiguous statutory

[4] Other states use similarly general terms like "manage" to define the practice of dentistry. See, *e.g.*, Md. Code Ann., Health Occ. § 4-101(l); Mo. Rev. Stat. § 332.071; N.J. Stat. Ann § 45:6-19; Wash. Rev. Code § 18.32.020(3). Statutory vagueness undermines the very purpose of the clear articulation standard, which is "designed to help identify conduct that warrants shelter from antitrust laws on grounds of federalism." FTC, *Report of the State Action Task Force* 25 (2003), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/report-state-action-task-force/stateactionreport.pdf. Instead, a general statutory grant of ambiguous authority is often misconstrued by self-interested market participants as a state policy to displace competition across an entire industry. The two are not the same.

language like "manages" or "controls," boards have sought to sweep business functions far removed from clinical care of patients within the exclusive province of licensed dentists, in order exclude competition from DSO-supported practices and maintain the status quo.

The North Carolina Board, for example, sought enactment of a bill that would define "management" of a dental practice to include (in a non-exhaustive list) such non-clinical functions as the purchase of supplies and inventory, the purchase or lease of equipment or office space, payment of vendors, establishing hours of operation, or use of "sweep accounts." See North Carolina H.B. 698, proposed § 90-40.2(e) (2011), http://www.ncga.state.nc.us/Sessions/2011/Bills/House/HTML/H698v1.html. The Board also sought for itself the authority to "review" (with no deadline for responding) all "management arrangements" and to "conduct random audits, inspections, and investigations" of the "books and records of any management company which enters into a management arrangement with a licensed dentist." *Id.* § 90-40.2(s). By contrast, traditional dental practices, unaffiliated with a DSO, would not be subject to the threat of "random" searches. Maryland's board is attempting the same thing, but through regulation rather than legislation, and further would include within the definition of "control" of a dental practice "decision[s] regarding the advertising of the practice," provider contracts with third-party payors (like insurance companies), and employment of "ancillary personnel." Notice of Proposed Action, 41 Md. Reg. 531 (proposed May 2, 2014) (to be codified at Md. Code Regs. 10.44.34), http://dhmh.maryland.gov/regs/Pages/10-44-34-Owner

ship-and-Management-of-a-Dental-Practice-(BOARD-OF-DENTAL-EXAMINERS).aspx.

The Texas State Board of Dental Examiners, a majority of whose members must be practicing dentists, see Tex. Occ. Code § 252.001(a), has also been extremely hostile to DSOs. The Texas board has likewise recently been considering proposed amendments to its regulations that would prohibit any dentist from entering a contract where a non-dentist would exercise sole control over certain non-clinical, wholly administrative tasks such as purchasing dental and non-dental equipment, accounting, bookkeeping, payroll, advertising and marketing, legal services, soliciting and negotiating contracts with third-party payors, and hiring and firing non-licensed or licensed staff. See Unofficial Proposed Amendments to 22 Tex. Admin. Code § 108.70 (2014); see also Unofficial Proposed Amendments to Ga. Comp. R. & Regs. 150-8-.01(s) (2014) (Georgia Board of Dentistry considering proposed amendments to its regulations that would define "unprofessional conduct" to include entering a contract where a non-dentist will perform administrative functions like scheduling, or provide financial services such as making or guaranteeing a loan in certain circumstances).[5]

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[5] The Texas board has also advocated for new legislation that would allow it to control virtually the entire DSO industry. See S.B. 151, 2012 Leg., 83(R) Sess. (Tex. 2012). The proposed legislation would require DSOs to register with the Texas board and pay annual fees, would place limits on what can be included in dental service agreements, and would impose restrictions on when DSO-affiliated dentists may share patient records with the DSO. See *ibid.* Although the Texas board has framed its campaign against DSOs as an effort to combat Medicaid fraud, there is no evidence

3. *In the absence of active state supervision, state boards construe ambiguous grants of authority broadly, to limit competition*

Even without new statutory authority (which the legislature declined to enact), the North Carolina Board has taken aggressive steps to exclude competition from DSO-affiliated dentists. An FTC review of the North Carolina Board's practices in connection with the proposed legislation revealed "strong evidence of the Board's hostility toward dentists' use of DSOs to help manage the non-clinical aspects of their practices." FTC NC DSO Letter at 6. In particular, the FTC noted that the Board had taken action "against a dentist who attempted to affiliate with a potential DSO entrant, and prohibited the DSO from entering North Carolina for five years," even though "there were no

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that concerns about healthcare fraud were specific to DSO-affiliated dentists. See John Davidson, *State Regulation of Dental Service Organizations: A Solution in Search of a Problem*, Tex. Pub. Policy Found., Ctr. for Health Care Policy (Apr. 2013). As one commentator observed, it is "difficult to see [the Texas board's] attempt to impose a regulatory regime on DSOs in particular as anything other than a protectionist scheme designed to benefit non-DSO-supported dental practices by giving them a competitive advantage." *Ibid.* The Kansas and Nevada dental boards have also taken steps to suppress DSOs, reading state laws to require that DSOs register with the boards, even though the Kansas statute contains no registration requirement whatsoever and the Nevada statute only requires registration if a person "manages" the business of a dental practice. See Kan. Stat. Ann § 65-1424; Nev. Rev. Stat. § 631.388. Requirements like these deter many dentists from working with a DSO out of fear that the increased scrutiny could result in adverse regulatory action by hostile state boards. See FTC NC DSO Letter at 5 & n.37.

allegations the dentist * * * was providing negligent or low quality care" or "any evidence that non-licensed individuals conducted any patient care" at the dentist's clinic. *Id.* at 2 & n.8 (internal quotation omitted). The FTC noted that "several DSOs ha[d] 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." *Id.* at 6.

The Board's cease-and-desist letters in this case were not issued in response to consumer harm, but in order to protect the private economic interests of the members who are practicing dentists and their constituent dentists. In about 2003, the Board began receiving letters from practicing dentists complaining about non-dentist providers of teeth whitening services. Pet. App. 75a. The complaints noted that the non-dentists in question were offering teeth whitening services *at lower prices*. *Ibid.* Almost none of the complaints referenced concern for harm to consumers. *Ibid.* The Board responded to these complaints by sending cease-and-desist letters with the "goal" of stopping non-dentists from providing teeth whitening services. *Id.* at 76a; see also *id.* at 103a-104a (statement of Board's Chief Operations Officer that the Board was "going forth to do battle" with non-dentist providers of teeth whitening services). The Board even issued cease-and-desist letters on the basis of a complaint alone, without any investigation into potential harm, and despite the fact that certain forms of teeth whitening products are so safe that they are available for purchase over the counter. *Id.* at 76a. Indeed, there was little question whether dentists needed to *perform* the teeth whiten-

ing services—they do not. Rather, dentists want to insist that teeth whitening services be performed subject to their "supervision," so that they can earn a profit on the service. See *id.* at 75a (explaining that the dentists' complaints referred to the low prices offered by non-dentist teeth whiteners). In that sense, the experiences of those offering teeth whitening services are much like the experiences of nurses, who are frequently the target of medical boards dominated by physicians who try to force nurses to work subject to a doctor's "supervision," limiting nurses' ability to practice independently within the full scope of their training and education and harming patient access. See Nursing Ass'ns Amicus Br. pt. I.A.

The list of state regulatory authorities seeking to entrench their positions against disruptive entrants is long, and demonstrates that the interest in suppressing competition often has nothing to do with, and is even contrary to, the interests of customers and patients. The Louisiana State Board of Embalmers and Funeral Directors—of which eight out of nine members are licensed funeral directors or licensed embalmers—ordered a group of Catholic monks to stop selling caskets priced significantly lower than those offered by funeral homes. *St. Joseph Abbey* v. *Castille*, 700 F.3d 154, 159 (5th Cir. 2012). While the board argued that the regulations were intended to protect consumers and also benefit public health, the Fifth Circuit found that the licensing requirements did nothing to ensure the quality of caskets, nor did they further any supposed public health benefits, especially in light of the fact that state law did not require use of a casket at all. See *id.* at 157, 162-165.

In similar fashion, state cosmetology boards have attempted to limit who can perform African-style hair-braiding services. In Washington, the State Department of Licensing threatened fines and disciplinary action against a small business owner if she continued to provide African hair braiding services without a state cosmetology license. See Complaint, *Sylla* v. *Kohler*, No. 2:14-cv-00885 (W.D. Wash. June 17, 2014). Other states have done likewise. See Jacob Goldstein, *So You Think You Can Be a Hair Braider?*, N.Y. Times, June 12, 2012, http://www.nytimes.com/2012/06/17/magazine/so-you-think-you-can-be-a-hair-braider.html?_r=2&adxnnl=1&pagewanted=1&adxnnlx=1403546484-CyQBbR0yazUdJsolQXkDHA (detailing Utah board's denial of an application for exemption from the requirement to hold a cosmetology license to practice hair braiding). Ironically, these boards insist on cosmetology education and licensure, even though cosmetology school provides no training on how to perform African hair braiding. *Ibid*; see also Alana Rocha, *Eyebrow Threading Regulations to Go Before High Court*, Tex. Tribune, Feb. 25, 2014, http://www.texastribune.org/2014/02/25/texas-eyebrow-threading-industry-under-microscope (noting Texas Department of Licensing and Regulation determination that eyebrow threading required cosmetology licensure, despite the fact that the service was not taught at cosmetology school).[6]

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[6] The Louisiana Horticulture Commission, which is comprised almost exclusively of market participants, see La. Rev. State § 3:3801, has acted in a similar fashion. Until 2010, one's ability to act as a retail florist required passing an examination that included a hands-on floral arrangement test administered by the Commission, that was graded based on entirely subjective criteria. *Id.*

State veterinary boards comprised of market participants have likewise attempted to extend their monopolies. In 2010, the Texas Veterinary Board enacted a regulation prohibiting non-veterinarians from filing animals' teeth, a service that is particularly important for horses. See Letter from Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission, to Loris Jones, Texas State Board of Veterinary Medical Examiners (Aug. 20, 2010), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-comment-texas-board-veterinary-medical-examiners-concerning-rule-573.17-regarding-animal-teeth-floating/100910texasteethfloating.pdf. As the FTC explained in opposing the regulation, the Texas board "cite[d] no evidence about injury to horses attributable to" non-veterinary horse teeth filers, nor did it "address how veterinary supervision might be related to improved animal health." *Id.* at 3. More recently, the Arizona Veterinary Board has asserted that only licensed veterinarians can work as animal massage therapists. See Karl Dickey, *Arizona crushes small business owners with anticompetitive laws*, examiner.com (Mar. 5, 2014), http://www.examiner.com/article/arizona-crushes-small-business-owners-with-anti-competitive-laws. Yet no similar licensing requirement exists for human massage therapists, and veterinarians are not required to learn massage in veterinary school. See *ibid.*

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§ 3:3807(A); David Muller, *Lawmakers weed out portion of state florist exams*, neworleanscitybusiness.com (June 16, 2010), http://neworleanscitybusiness.com/blog/2010/06/16/lawmakers-weed-out-portion-of-state-florist-exams.

The above experiences demonstrate that market participants do not shed their self-interest when they take positions on state professional boards. They continue to have an interest in suppressing competition in the form of new business models or lower cost providers. Indeed, the additional power they enjoy as a state regulatory body makes it more likely that they will succeed in suppressing competition. State dental boards, like the North Carolina Board, have succeeded in maintaining solo practice as the dominant business model long after it ceased to be the dominant practice for medical doctors. The threat that such boards pose to competition warrants requiring them to satisfy the active state supervision requirement in order to claim the benefit of state-action antitrust immunity.

B. By Suppressing Competition, State Boards Dominated By Market Participants Harm Consumers, Including By Reducing Access To Critical Health Care

Failure to subject state boards bent on erecting entry barriers to an active supervision requirement threatens consumers with substantial harm. The "fundamental national values of free enterprise and economic competition" confer real and practical benefits on consumers. See *FTC* v. *Phoebe Putney*, 133 S. Ct. 1003, 1010 (2013). Competition produces efficiencies that decrease costs and expand access. See *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. at 694-695. In recent years, most areas of the medical profession have seen an evolution and diversification of business models, which has resulted in lower prices while maintaining quality of care. The market for dental services, by contrast, has remained largely under the control of boards dominated

by market participants who have suppressed competition, with the consequence of reduced access to dental care for consumers.

Competition in the market for administrative dental support services, especially the efficiency generated by DSOs, leads to better access to care. By bringing managerial experience and administrative services to dental practices owned by medical professionals, DSOs allow quality dental care to be provided at lower costs to patients. DSOs can help small dental practices to "finance the practice, manage billing, handle payroll, file insurance and execute other administrative tasks." FTC NC DSO Letter at 4 (quoting Dr. Clifton Cameron). By taking over the business aspects of dentistry from dentists who are ill-trained for that task, DSOs "allow[] dentists to spend more time on patient care and less time on administrative tasks." *Id.* at 6. These increased efficiencies can help reduce costs and thereby enable DSO-affiliated dentists to more readily "accept dental insurance from patients." *Id.* at 4 (quoting Dr. Clifton Cameron).

Entry of DSOs into a state can dramatically improve access to dental care. In part due to their greater efficiencies, " 'dental 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.' " FTC NC DSO Letter at 6 (quoting Robert Fontana, Chief Executive Officer of Aspen Dental Management, Inc.). Moreover, the DSO business model emphasizes new entry and "focuses its entry and expansion efforts on markets in which dentists are in short supply." *Ibid.* By opposing

entry of DSOs, state dental boards like North Carolina's reduce access to dental care in their states.

Allowing more efficient and lower cost business models in dentistry could help redress a significant gap in dental care. The disproportionate incidence of oral diseases within the nation's most vulnerable groups, including children and the poor, is well-documented. See, *e.g.*, Dep't Health & Human Servs., *Oral Health in America: A Report of the Surgeon General* vii (2000), http://www.nidcr.nih.gov/DataStatistics/SurgeonGeneral. According to a GAO study, "42 percent of adults with tooth or mouth problems did not see a dentist in 2008 because they did not have dental insurance or could not afford the out-of-pocket payments, and in 2011, 4 million children did not obtain needed dental care because their families could not afford it." GAO, *Dental Services: Information on Coverage, Payments, and Fee Variation*, (Sept. 2013), http://www.gao.gov/assets/660/657454.pdf.

In North Carolina, whose Board has aggressively fought the entry of DSO-affiliated practices, access to dental care is particularly inadequate. North Carolina consistently ranks near the bottom of the nation in terms of dentist-to-population ratio. See A Report on Health Care Resources in North Carolina, North Carolina Health Professions 2012 Data Book 23-24 (effective Apr. 2014), http://www.shepscenter.unc.edu/hp/publications/2012_HPDS_DataBook.pdf. And a vast majority of North Carolina's counties continue to be listed as Dental Health Professional Shortage Areas. See Dep't Health & Human Servs., Health Resource & Servs. Admin. (updated June 23, 2014), http://hpsafind.hrsa.gov/HPSASearch.aspx. By providing managerial

and administrative functions that improve efficiency and lower costs, DSOs could significantly expand access in the North Carolina market.

But despite the critical problem of inadequate access to dental care, many state dental boards continue to restrict it. In addition to the efforts to restrict DSO-affiliated practices detailed above, state boards impose other requirements that favor the traditional business model but inhibit increased access to care. In recent years the Louisiana State Board of Dentistry, for example, has imposed requirements on mobile dentist practices above and beyond those that apply to office-based dental practices. For instance, the Board authorizes unannounced inspections of mobile clinics, but generally prohibits them for traditional brick-and-mortar dentist facilities. See La. Admin. Code tit. 46, § 313(J). As the FTC noted in objecting to these new burdens, additional regulations on mobile dentists are unlikely to improve quality of care, yet they will reduce access to care by increasing costs and, in some cases, discouraging mobile clinics. See Letter from Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission, to Barry Ogden, Executive Director, Louisiana State Board of Dentistry (Dec. 18, 2009), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-state-board-dentistry-concerning-proposed-modifications-louisianas/091224commentladentistry.pdf.

The risk of anticompetitive regulation decreasing consumer access is not unique to dental boards, but rather inherent to state boards dominated by market participants. In 2011, for example, the North Carolina State Board of Opticians, which is comprised of five li-

censed dispensing opticians and just two consumer members, N.C. Gen. Stat. § 90-238, considered proposed regulations on out-of-state vendors and online merchants that would not apply to office-based practices. Specifically, the proposed regulations would subject out-of-state optical practices and internet sites to onerous and costly registration requirements not applicable to North Carolina businesses and would require internet sites to give customers additional notices and waivers not required of traditional brick-and-mortar practices. See Letter from Susan S. DeSanti, Director, Office of Policy Planning, Federal Trade Commission, to Sue M. Kornegay, NC State Board of Opticians (Jan. 13, 2011), http://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-north-carolina-state-board-opticians-concerning-proposed-regulations-optical-goods/1101ncopticiansletter.pdf. As the FTC explained in its letter opposing the regulations, these additional requirements not only lacked any "health and safety rationales," they would also impose greater costs on North Carolina consumers. *Ibid.*

The active state supervision prong of the state action immunity doctrine will reduce the likelihood of boards adopting anticompetitive regulation that reduce consumer access. Active supervision requires the state, acting as the state, to make a substantive judgment that self-interested market actors acted with fidelity to state policies. See *Patrick* v. *Burget*, 486 U.S. 94, 102 (1988). When such regulation does occur, the active state supervision requirement will ensure that the policy reflects the judgment of independent state officials responsible to consider the interests of the

general public rather than merely the interests of private market participants.

C. Limited Review Not Amounting To Active Supervision Will Fail To Stop Boards From Suppressing Competition

Market participant members of state boards have considerable powers at their disposal. In the absence of an active state supervision requirement, those boards can wield that authority with little independent check by disinterested state officials. Although the Board suggests that the proper check on a board's self-interest is that provided by administrative law principles and judicial review, see Pet. Br. 38, many of the anticompetitive actions that a state board can take are not immediately subject to review. And deferential judicial APA-type review of a board construing ambiguous statutory terms is no substitute for the check provided by independent state officials with authority to review the substance of a board's action as a matter of policy.

The North Carolina Dental Board's cease-and-desist letters to non-dentist providers of teeth whitening services are prime examples of how a state regulatory body can utilize state-granted authority to suppress competition without its conduct being subjected to any effective independent review. The Board sent cease-and-desist letters to 29 non-dentist teeth whitening manufacturers and providers. Pet. App. 76a. These letters were on official Board letterhead and stated in capitalized lettering: "NOTICE AND ORDER TO CEASE AND DESIST," "NOTICE TO CEASE AND DESIST," "CEASE AND DESIST NOTICE," or

"NOTICE OF APPARENT VIOLATION AND DEMAND TO CEASE AND DESIST." See, *e.g.*, J.A. 10, 12, 17, 19, 24, and 26. Many of the letters quoted or referenced North Carolina state laws and regulations. The Board's March 21, 2007 letter to the owner of a local hair salon is demonstrative. *Id* at 10. In that letter, the Board explained that it was "investigating a report that you are engaged in the unlicensed practice of dentistry," noting that "[p]racticing dentistry without a license in North Carolina is a crime." *Ibid.* The letter "ordered" the salon to "CEASE AND DESIST" any "activity constituting the practice of dentistry," and it quotes certain excerpts of state law. *Ibid.* The effect of the letter was to give the appearance that the Board was giving a legal command with which the salon had to comply. *Ibid.*

Similarly, the letters to mall operators cited to North Carolina state law, asserted that "The unauthorized practice of dentistry is a misdemeanor," and claimed that the teeth whitening taking place at the mall kiosks was "illegal." J.A. 22. As the FTC explained in its opinion below, part of the reason that the Board's letters were effective in causing non-dentists to stop providing teeth whitening services was the "perception of some recipients that the letters carried the force of law." Pet. App. 77a. The Board also enlisted the help of the North Carolina Board of Cosmetic Art Examiners, which posted a notice on its website that teeth whitening "constitutes the practice of dentistry," noting that "unlicensed practice of dentistry in our state is a misdemeanor." *Id.* at 77a-78a. The effect of this post was exactly what the Board desired, for at

least some cosmetologists stopped providing teeth whitening services as a result. *Id.* at 78a.

Importantly, the Board could succeed in suppressing competition before any review of its conduct. The Board's response to the FTC suggested that recipients of the letters were free to "simply ignore the letter and assert as a defense to the Dental Board's request for an injunction their contention that their activities do not constitute the practice of dentistry or seek a declaratory ruling or judgment on the issue of whether their activities constitute the practice of dentistry." See Response to Complaint, *In re N.C. Bd. of Dental Exam'rs*, No. 9343, ¶ 19 (F.T.C. July 6, 2010) (citing N.C. Gen. Stat. § 150B-4), http://www.ftc.gov/sites/default/files/documents/cases/130604ncboardopinion.pdf. The Board's response only underscores how the Board's unsupervised acts themselves deter new entrants from challenging incumbents. Recipients who believed they were under a lawful order to cease their activities were put to the burden of initiating litigation in order to establish their right to continue to engage in teeth whitening services. Such anticompetitive threats are especially likely to succeed without challenge when directed at small businesses or third parties with little to gain from a challenge, such as the mall operators. The cost to them of challenging the Board's order would likely be far more than the rent received from teeth whitening kiosks.

As with this example, in many other instances, anticompetitive board actions will not be subject to review at all. To the extent a state's administrative review mechanism requires final agency action, board actions like soliciting the North Carolina Cosmetology

Board's support would not be subject to review. Nonbinding guidance warning that a board views certain actions as illegal would not be final agency action subject to immediate review, nor would a letter threatening, or even the initiation of, costly investigation. See N.C. Gen. Stat. § 150B-43; cf. 5 U.S.C. 704.

Even if judicial review is available, such review may not encompass the substance of the board's anticompetitive policy. Where, for example, a board is construing an ambiguous statutory term, courts may be inclined to defer to the board's construction under principles of agency deference. Thus, judicial review is unlikely to provide an effective check on a board's choice to promote the self-interest of market participant members over the interests of the general public. Effective review of a board's anticompetitive policy can only occur if the reviewing officials have authority to review the *substance* of the action as a matter of public policy. The requirements for state action immunity ensure that the state actually passes on the substance of conduct undertaken by actors purporting to exercise state power. See *Patrick*, 486 U.S. at 102. There is no reason to jettison the active supervision requirement for obtaining immunity from the Sherman Act, where, as here, the absence of state supervision means the substance of the Board's anticompetitive policy has not been reviewed by independent state officials.

CONCLUSION

For the foregoing reasons, the judgment of the court of appeals should be affirmed.

Respectfully submitted.

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