



UNITED STATES OF AMERICA

FEDERAL TRADE COMMISSION

WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

March 3, 2017

The Hon. Peggy Lehner
The Ohio State Senate
Ohio Statehouse
Columbus, OH 43215

Dear Senator Lehner:

We appreciate the opportunity to respond to your invitation for comments on the likely competitive impact of Senate Bill 330 (“S.B. 330” or “the Bill”).¹ In particular, you asked us to comment on the competitive effects of the Bill in increasing access to quality health care, including the Bill’s provisions for licensing dental therapists—a relatively new type of “mid-level” dental practitioner who offers some of the same basic services offered by dentists.²

S.B. 330 may allow dental hygienists to work more often under general supervision without a dentist on the premises, which could enhance competition and expand access to hygiene services. Under the Bill, however, dental hygienists would still have to obtain written supervision agreements from dentists. Hence, the Bill’s competitive benefits would depend on how often supervising dentists authorize general supervision in these written agreements.

S.B. 330 also would provide for the licensure of dental therapists, which could increase consumer choice among providers of certain dental services, enhance competition, reduce prices, and expand access to dental care. S.B. 330 would, however, limit these potential benefits by allowing dental therapists to practice only in certain underserved settings. This restriction would prevent many patients in Ohio from obtaining lower-cost and more accessible dental care from a dental therapist. In addition, as with dental hygienists, dental therapists could practice under general supervision only if they had explicit written authorization by potentially competing dentists. This requirement could further restrict the availability of benefits that otherwise would result from introducing the dental therapy profession in Ohio.

Accordingly, we encourage the Ohio legislature to consider expanding general supervision of dental hygienists and licensure of dental therapists, and to avoid limiting general supervision and dental therapy practice, except as necessary to address well-founded patient health and safety concerns.

I. INTEREST AND EXPERIENCE OF THE FEDERAL TRADE COMMISSION

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.³ Competition is at the core of America's economy.⁴ It gives consumers the benefits of lower prices, higher quality products and services, and increased innovation. Because of the importance of health care competition to the economy and consumer welfare, anticompetitive conduct in health care markets has long been a key focus of FTC law enforcement,⁵ research,⁶ and advocacy.⁷ In particular, many of our recent state advocacy comments have considered the competitive benefits of affiliated practitioners such as advanced practice registered nurses ("APRNs") and physician assistants, focusing on how proposed scope of practice and supervision provisions affect those benefits.⁸

FTC staff has addressed similar competition issues related to oral health care⁹ in both law enforcement actions and policy initiatives. In 2003, the Commission sued the South Carolina Board of Dentistry, charging that the Board had illegally restricted dental hygienists from providing preventive dental services in schools unless students were first examined by a dentist,¹⁰ thereby unreasonably restraining competition and depriving thousands of economically disadvantaged schoolchildren of needed dental care, with no justification.¹¹ The Board ultimately entered into a consent agreement settling the charges.¹²

In January 2016, FTC staff urged the Georgia State Senate to consider the procompetitive benefits of a bill that sought to broaden the availability of dental hygiene services by expanding the settings where hygienists could provide their services without direct supervision by a dentist on the premises.¹³ Thus, the bill could have increased access to hygiene services in rural or underserved areas where dentists are scarce or unavailable.¹⁴ Similarly, FTC staff opposed rules proposed by the Georgia Board of Dentistry in 2010¹⁵ and the Maine Board of Dental Examiners in 2011¹⁶ because they would have required a dentist to be present for a dental hygienist to provide certain preventive services, which likely would have reduced access and increased costs.

FTC staff comments have also supported establishing a dental therapy profession because it could increase the output of basic dental services, enhance competition, reduce costs, and expand access to dental care. In letters to the Commission on Dental Accreditation ("CODA"), FTC staff commended CODA's proposed accreditation standards as an important first step in encouraging the development of a nationwide dental therapy profession. Staff pointed out, however, that statements in the proposed standards regarding supervision of dental therapists could inhibit state-level legislation allowing dental therapists to conduct certain procedures in the absence of an on-site dentist, thereby limiting the competitive benefits that could arise from the establishment of the profession.¹⁷

As always, the FTC comments on pending legislation with a focus on promoting competition consistent with patient safety for the benefit of consumers.

II. CURRENT OHIO LAW AND S.B. 330's PROPOSED AMENDMENTS

A. Supervision of dental hygienists

S.B. 330 would expand the circumstances in which dental hygienists can work under general supervision, without a dentist on the premises. Although the default supervision level in Ohio's dental practice act is direct supervision,¹⁸ currently there are certain circumstances where a dentist need not be present: for a limited time and a limited set of procedures, when the dentist

has examined the patient within the past year;¹⁹ for school-based dental hygiene, public health, and other programs approved by the dental board, after examination and diagnosis by a dentist;²⁰ and to apply fluoride varnish and discuss nutrition.²¹ S.B. 330 retains these provisions, but would potentially allow a dental hygienist to work under general supervision in additional circumstances, pursuant to a written supervision agreement.

Specifically, under certain circumstances S.B. 330 would allow a dental hygienist to work under the general supervision of a remote dentist, even when the dentist has not previously examined the patient.²² Dental hygienists would be required to enter into a supervision agreement with a dentist that specifies the conditions under which general supervision is authorized,²³ and demonstrate proficiency in each service authorized in the agreement.²⁴ S.B. 330 also would reduce the number of hours of supervised practice required before a dental hygienist is eligible for general supervision from “at least one year and a minimum of one thousand five hundred hours,”²⁵ to 400 hours.²⁶

The potentially broad general supervision provisions in S.B. 330 would replace the more limited provisions of Ohio’s Oral Health Access Supervision Program (“OHASP”),²⁷ which would be repealed.²⁸ OHASP only allows general supervision of dental hygienists when they provide services at certain public health facilities and settings, such as facilities that are located in a dental health resources shortage area and provide services to the indigent or those covered by Medicaid.²⁹ Although OHASP has no prior examination requirement, it requires hygienists to schedule an appointment with a dentist after a patient receives care pursuant to the program.³⁰ In addition, both dentists and dental hygienists must obtain a special permit to participate in the program, and dental hygienists must take a course in the practice of dental hygiene under the oral health access provision.³¹

S.B. 330’s provisions for general supervision of dental hygienists, as well as the current general supervision provisions at OHIO REV. CODE ANN. § 4715.22 that would be retained by the Bill, have no comparable requirements limiting general supervision to certain public health facilities or underserved locations, no prior or subsequent examination requirements, and no permit requirements.

B. Licensure of dental therapists and dental hygienist therapists

S.B. 330 would provide for licensure of dental therapists who graduate from a CODA-accredited dental therapy education program and pass a board-required examination.³² S.B. 330 would, however, allow dental therapists to practice only in certain underserved settings, including designated dental care health professional shortage areas and any practice in which at least 20 percent of the supervising dentist’s patients are Medicaid recipients.³³ S.B. 330 imposes these restrictions on all practice settings, regardless of the supervision level.

The default level of supervision of a dental therapist would require a dentist to be physically present at the dental therapist’s location of practice.³⁴ S.B. 330 would, however, allow dental therapists to practice under general supervision – without a dentist present or having previously examined or diagnosed the patient – if authorized by a written supervision agreement between the dentist and dental therapist.³⁵ The required terms of an agreement for the supervision of dental therapists³⁶ would be the same as those for supervision of dental hygienists.³⁷

S.B. 330 also would provide for licensure of dental hygienist therapists (practitioners holding both dental hygiene and dental therapy licenses).³⁸ The Bill appears to require dental hygienist therapists to maintain both underlying licenses. S.B. 330 would, however, apply any continuing education requirements completed to maintain a dental hygienist license toward the satisfaction of dental therapy continuing education requirements, and vice versa.³⁹

III. LIKELY COMPETITIVE IMPACT OF S.B. 330

A. General Supervision of Dental Hygienists

Laws and regulations that require hygienists to work under the direct supervision of dentists are a significant barrier to the use of dental hygienists outside of dentists' offices and in dental shortage areas.⁴⁰ When dentists are not physically available for in-person supervision, dental hygienists may be completely excluded from providing dental services within the scope of their training, skills, and experience. Even when dentists are available, a direct supervision requirement can result in duplication of efforts and inefficient use of resources.⁴¹ Similarly, blanket requirements for the prior or subsequent examination of a patient by a dentist, regardless of whether that examination is medically necessary, encumber the provision of hygiene services, especially in dental shortage areas.⁴² Over the last 20 years, the trend among most states has been to enhance access to dental hygienists by relaxing supervision requirements and requiring only general supervision.⁴³ Many states go even further, allowing direct access to dental hygienists under certain circumstances.⁴⁴

By avoiding rigid limitations on the settings, procedures, and circumstances under which a dental hygienist can provide preventive services under general supervision, S.B. 330 would likely enhance access and competition in the provision of dental hygiene services. The Bill would likely be more effective than OHASP in promoting less restrictive supervision because dentists could authorize general supervision in any setting, without the need for licensed practitioners to obtain an additional permit.⁴⁵ Although states sometimes allow less restrictive supervision in underserved settings to improve access in those areas,⁴⁶ that limitation is not based on a health and safety rationale, and the need for improved access is not limited to such settings. Indeed, the Institute of Medicine recommends that state legislatures increase access to basic oral health care by amending dental practice acts to allow allied dental professionals such as hygienists to work to the full extent of their education and training "in a variety of settings under evidence-supported supervision levels[.]"⁴⁷

By increasing the availability of dental hygienists' services outside of dentists' offices, SB 330 could increase the number of providers of preventive dental care and the convenience of care, especially at times and locations where dentists are not available.⁴⁸ The resulting increase in competition, greater use of lower cost practitioners, and avoidance of unnecessary payments to dentists could reduce the cost of providing dental care and prices.⁴⁹ Increasing the availability of dental hygienists at settings where dentists are unavailable would not only make care more convenient, but also would likely reduce patients' transportation costs, potentially leading to savings for government benefit programs that pay for transportation.⁵⁰

Greater competition arising from lower supervision levels may thus enhance access to affordable preventive services and mitigate the broader health consequences of dentist shortages.⁵¹ Indeed, one study found that enabling "hygienists to provide services within their professional competencies under reasonable supervision requirements may yield improvements over time in the oral health status of the populations served."⁵²

By contrast, retention of the current restrictions on general supervision would likely limit competition and decrease access to dental hygienists without furthering any legitimate health and safety concerns. Various authorities have concluded that direct supervision of dental hygienists is not necessary for them to provide preventive services safely. According to the National Governors Association, there is no clear evidence to support state dental boards' alleged concerns about quality and safety, which boards sometimes raise to justify restricting hygienists from practicing without supervision in settings where dentists are not available.⁵³ The Institute of Medicine has likewise concluded that restrictive scope of practice and supervision laws and regulations governing dental hygienists "are often unrelated to competence, education and training, or the safety" of the services they provide.⁵⁴

One potentially significant drawback of S.B. 330's provisions for general supervision of hygienists is that, despite enhanced opportunities for dentists to allow general supervision, S.B. 330 does not guarantee that improvement. Rather, the extent of the change would depend entirely on the decisions of dentists regarding authorization of general supervision in each written supervision agreement. A written supervision agreement might not authorize general supervision at all, or it might allow general supervision only in certain settings or circumstances, such as after a dentist's examination of the patient.⁵⁵ While granting such discretion to a dentist provides flexibility, it could undercut the Bill's potential to increase the use of general supervision in a wide range of settings. Importantly, some dentists might perceive a threat of competition from dental hygienists for the provision of certain dental services, which might affect dentists' willingness to authorize general supervision.

Accordingly, we encourage Ohio legislators to consider the potential effects on competition and access of possible limitations on general supervision in written supervision agreements. We also urge legislators to consider less restrictive alternatives that would still address any legitimate and substantiated health and safety concerns. For example, the Bill could make general supervision the default supervision level, with no prior examination requirements. Alternatively, the Bill could allow direct access to dental hygienists without a supervision agreement, as many states have done.⁵⁶

B. Licensure of Dental Therapists

By providing for the licensure of dental therapists, S.B. 330 could potentially enhance competition, access, and quality, and also lead to lower prices for a range of dental services. Because the oral health workforce is not well distributed, access to dental care may be inadequate in some parts of Ohio, as it is in some other parts of the United States.⁵⁷ In dental care, as in other areas of health care, workforce modifications expanding the use of mid-level providers, such as dental therapists, can increase the supply of basic services and improve the overall quality and convenience of care. Such measures are viewed as an important strategy to address access and cost challenges.⁵⁸

Dental therapists are likely to be most effective in expanding access to cost-effective care, especially to the underserved, when they are allowed to practice under the general supervision of a remotely-located dentist.⁵⁹ Although dental therapists generally receive lower compensation than dentists because of their more limited training and the narrower scope of services they are typically authorized to provide,⁶⁰ the main potential for cost savings from the use of dental therapists depends "on whether duplication in providers arises and whether the profit arising from care provided by lower-paid therapists accrues to dentists, insurers, or

patients.”⁶¹ A requirement to have a supervising dentist on the premises will likely lead to unnecessary duplication of resources and thereby undercut the cost savings that otherwise might arise from the use of lower-cost providers, effectively defeating a major purpose of expanding the supply of dental therapists.⁶²

While S.B. 330 would allow supervision of dental therapists by remotely located dentists, the Bill lets dentists decide whether to permit general supervision and under what circumstances. Thus, as discussed above with regard to dental hygienists, we encourage Ohio state legislators to consider whether and to what extent dentists might include limitations on the use of general supervision in written supervision agreements, how such limitations could affect competition and access, and whether less restrictive alternatives could better promote competition while also addressing any legitimate and substantiated health and safety concerns.⁶³

We also encourage Ohio legislators to consider less restrictive alternatives to S.B. 330’s requirement that dental therapists practice *only* in underserved settings. While underserved settings, by definition, have the most acute shortage of practitioners, the need for greater access to oral health care is not limited to formally designated shortage areas or practices with at least 20 percent Medicaid recipients. Because many people do not have dental insurance, and even the insured typically have significant out-of-pocket expenses, cost is a major barrier to oral health care.⁶⁴ Thus, restricting dental therapists to specific underserved settings would likely inhibit the ability of dental therapists to provide dental services to many people who would benefit from lower-cost dental care.⁶⁵

Restricting dental therapy practice solely to underserved settings may also discourage entry into the field and development of the profession,⁶⁶ further limiting the potential competitive benefits arising from dental therapy licensure. An individual considering a dental therapy career may consider the limited practice settings, as well as the small number of states that currently provide for dental therapy licensure,⁶⁷ when deciding whether to make the financial and time commitment that licensure would entail. Thus, Ohio legislators may wish to consider whether less restrictive alternatives could be equally, or perhaps more, effective in improving access to oral health care in underserved areas and populations.

In other health care professions, programs that aim to encourage practice in underserved areas often require a time-limited commitment to serve at an underserved location. For example, the National Health Service Corps of the Health Resources & Services Administration provides scholarships or loan repayments to students or graduates of medical, dental, and mental health professional schools in exchange for a two-to-three-year commitment to work in a health professional shortage area.⁶⁸ Ohio also took this approach in 2014 when it enacted the Dental Hygienist Loan Repayment Program, which provides repayment for loans in exchange for at least a two-year commitment to provide hygiene services in a dental health resources shortage area.⁶⁹ We suggest that Ohio legislators consider whether this approach or another less restrictive alternative could address the goals of S.B. 330 with respect to encouraging dental therapists to practice in underserved settings.⁷⁰

C. Licensure of dental hygienist therapists

S.B. 330 would recognize those who hold both dental hygiene and dental therapist licenses as dental hygienist therapists, but this would create tension in light of the Bill’s other provisions: on the one hand, allowing general supervision of dental hygienists in *any* setting (regardless of whether it is underserved), while on the other hand requiring that more highly

trained dental therapists practice only in *underserved* settings. Dental therapy is often viewed as a potential next step up the career ladder for dental hygienists who seek greater responsibility and compensation.⁷¹ Ohio legislators should consider whether dental hygienists, empowered by S.B. 330 to provide preventive services under general supervision in any setting, might be discouraged from seeking licensure as dental therapists. They might perceive it as a step backwards on the career ladder if they are restricted to practicing solely in underserved settings when providing dental therapy services not within the dental hygiene scope of practice.

IV. CONCLUSION

By potentially broadening the ability of dental hygienists to work under general supervision and by providing for the licensure of dental therapists, S.B. 330 could benefit consumers by increasing choice, competition, and access to care, especially for the underserved. The ability of hygienists and dental therapists to work without a dentist on site is particularly important in underserved areas, where dentists may not be available. Accordingly, we respectfully suggest that legislators consider whether requiring a dentist to authorize general supervision of these practitioners is necessary to address any legitimate and substantiated health and safety concerns, and whether a less restrictive alternative might achieve such goals without unduly burdening competition. We also encourage the legislature to consider the effects on competition, access to care, and development of the dental therapy profession of allowing dental therapists to practice only in underserved settings. There is no health and safety basis for this restriction. In our view, less restrictive alternatives could be equally, or perhaps more effective, in encouraging dental therapists to enter the profession and provide care in underserved settings.

We appreciate your consideration.

Respectfully submitted,

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¹ This letter expresses the views of staff in the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition. The letter does not necessarily represent the views of the Federal Trade Commission or of any individual Commissioner. The Commission, however, has authorized us to submit these comments.

² Letter from State Senator Peggy Lehner, Ohio Senate, to Tara Koslov, Acting Dir., Office of Policy Planning, FTC (Sept. 16, 2016) (on file with Office of Policy Planning). We understand that bills containing nearly identical provisions will be introduced for consideration by the Ohio legislature imminently.

³ Federal Trade Commission Act, 15 U.S.C. § 45.

⁴ *Standard Oil Co. v. FTC*, 340 U.S. 231, 248 (1951) (“The heart of our national economic policy long has been faith in the value of competition.”).

⁵ See generally MARKUS H. MEIER ET AL., FTC, OVERVIEW OF FTC ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2017), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/overview_health_care_january_2017.pdf.

⁶ See, e.g., FTC & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), <http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf>.

⁷ FTC and staff advocacy can include letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, amicus briefs, or reports. See, e.g., Comment from FTC Staff to the Delaware Bd. of Speech/Language Pathologists, Audiologists & Hearing Aid Dispensers (Nov. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-delaware-board-speech/language-pathologists-audiologists-hearing-aid-dispensers-regarding-its-proposed-revisions-its/161130_ftc_dealers_final_.pdf; Brief of Amicus Curiae Federal Trade Commission in Support of No Party, In re Nexium (Esomeprazole) Antitrust Litig., 842 F.3d 34 (1st. Cir. 2016) (No. 15-2015), https://www.ftc.gov/system/files/documents/amicus_briefs/re-nexium-esomeprazole-antitrust-litigation/160212nexiumbrief.pdf; FTC STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES (2014), https://www.ftc.gov/system/files/documents/advocacy_documents/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolycypaper.pdf.

⁸ See, e.g., Comment from FTC Staff to the Dep't of Veterans Affairs (July 25, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/comment-staff-ftc-office-policy-planning-bureau-competition-bureau-economics-department-veterans/v160013_staff_comment_department_of_veterans_affairs.pdf (supporting proposed rule that would allow APRNs to provide services required by the VA without the oversight of a physician); Comment from FTC Staff to the Iowa Dep't of Public Health (Dec. 20, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-professional-licensure-division-iowa-department-public-health-regarding-proposed/v170002_ftc_staff_comment_to_iowa_dept_of_public_health_12-21-16.pdf (regarding the appropriate level of supervision of physician assistants); FTC STAFF, POLICY PERSPECTIVES, *supra* note 7 (presenting an in depth analysis of the competitive effects of statutes and rules governing the scope of practice and supervision of APRNs.)

⁹ See, e.g., Comment from FTC Staff to the Tex. State Bd. of Dental Exam'rs (Oct. 6, 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-texas-state-board-dental-examiners/141006tsbdecomment1.pdf (concerning proposed restrictions on the ability of Texas dentists to enter into agreements with non-dentists for administrative services); *N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101 (2015) (upholding an FTC ruling that the North Carolina State Board of Dental Examiners illegally thwarted lower-priced competition by engaging in anticompetitive conduct to prevent non-dentists from providing teeth whitening services to consumers in the state); Comment from FTC Staff to the La. State Bd. of Dentistry (Dec. 18, 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-state-board-dentistry-concerning-proposed-modifications-louisianas/091224commentladentistry.pdf (concerning proposed rules on the practice of portable and mobile dentistry); Comment from FTC Staff to Timothy G. Burns, State Representative, La. House of Representatives (May 1, 2009), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-louisiana-house-bill-687-practice/v090009louisianadentistry.pdf; Comment from FTC

Staff to Sam Jones, State Representative, La. House of Representatives (May 22, 2009), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-louisiana-house-representatives-concerning-louisiana-house-bill-687-practice/v090009louisianahb687amendment.pdf (concerning legislation on the practice of in-school dentistry); *see generally* *Advocacy Filings by Subject, Dentistry*, FED. TRADE COMM’N, https://www.ftc.gov/policy/advocacy/advocacy-filings?field_advocacy_document_terms_tid=5302.

¹⁰ *See* S.C. State Bd. of Dentistry, 138 F.T.C. 229, 233-40 (2004).

¹¹ *See id.* at 232, 268-80.

¹² S.C. State Bd. of Dentistry, 144 F.T.C. 615, 628 (2007) (decision and order). The Board sought to have the complaint dismissed on the ground that its actions were exempt from the antitrust laws by virtue of the state action doctrine, but the Commission denied the motion to dismiss. S.C. State Bd. of Dentistry, 138 F.T.C. 229 (2004).

¹³ For an explanation of “direct supervision” and other terms used to describe supervision of dental hygienists by dentists, *see* Am. Dental Hygienists’ Ass’n (“ADHA”), *Dental Hygiene Practice Act Overview: Permitted Functions and Supervision Levels by State* (Dec. 2016), <https://www.adha.org/resources-docs/7511-Permitted-Services-Supervision-Levels-by-State.pdf> (under direct supervision, a “dentist needs to be present;” under indirect supervision, a “dentist must authorize [the] procedure and be in the dental office when the procedure is performed;” under general supervision, a “dentist needs to authorize prior to services, but need not be present;” under direct access, “hygienists can provide services as s/he determines appropriate without specific authorization”).

¹⁴ *See* Comment from FTC Staff to Valencia Seay, State Senator, Ga. State Senate (Jan. 29, 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-georgia-state-senator-valencia-seay-concerning-georgia-house-bill-684/160201gadentaladvocacy.pdf. The Georgia State Senate did not adopt the bill.

¹⁵ Comment from FTC Staff to the Ga. Bd. of Dentistry (Dec. 30, 2010), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-georgia-board-dentistry-concerning-proposed-amendments-board-rule-150.5-0.3-governing-supervision-dental-hygienists/101230gaboarddentistryletter.pdf (opposing adoption of proposed rule changes that would have required indirect supervision by a dentist for dental hygienists providing dental hygiene services at approved public health facilities, and which could have been interpreted to require a dentist’s initial diagnosis of all patients in such settings). The Board did not adopt the proposed rule requiring indirect supervision. *See* Comment from FTC Staff to Valencia Seay, *supra* note 14, at n.13 and accompanying text. Currently, Georgia regulations require a dentist to authorize the services provided by dental hygienists in certain approved settings, either in person, through video conferencing, by written standing orders, or through department protocols. *See* GA. COMP. R. & REGS. 150-5-.03(3)(b).

¹⁶ Comment from FTC Staff to the Me. Bd. of Dental Exam’rs (Nov. 16, 2011), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-maine-board-dental-examiners-concerning-proposed-rules-allow-independent-practice/111125mainedental.pdf (opposing adoption of proposed rules that would have restricted the scope of practice of Independent Practice Dental Hygienists (“IPDH”) participating in a pilot project designed to improve access to care in underserved areas of the state, by preventing them from taking certain radiographs without a dentist present). The Board subsequently voted to allow IPDHs to take only those certain x-rays.

¹⁷ *See* Comment from FTC Staff to CODA (Dec. 2, 2013), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/131204codacomment.pdf (concerning supervision requirements in proposed accreditation standards for dental therapists); Comment from FTC Staff to CODA (Nov. 21, 2014), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-commission-dental-accreditation-concerning-proposed-accreditation-standards-dental/141201codacomment.pdf (urging implementation of accreditation standards for dental therapists). CODA did not include statements about supervision of dental therapists by dentists and dentists’ responsibility for diagnosis and treatment planning in the accreditation standards that it adopted. *See id.* CODA subsequently voted to implement the standards. *See* CODA, ACCREDITATION

STANDARDS FOR DENTAL THERAPY EDUCATION PROGRAMS 3 (2015),
<http://www.ada.org/~media/CODA/Files/dt.pdf> (standards implemented on Aug. 7, 2015).

¹⁸ See OHIO REV. CODE ANN. § 4715.22(B).

¹⁹ See OHIO REV. CODE ANN. § 4715.22(C) (dental hygiene services may be provided under general supervision for not more than 15 consecutive business days; cannot include “procedures while the patient is anesthetized, definitive root planning, definitive subgingival curettage, or other procedures” identified by the state dental board; and the supervising dentist must have “examined the patient not more than one year prior to the” provision of services by the hygienist). If dental hygiene services are provided in a health care facility, all other requirements must be met, and a physician must be present in the facility when the services are provided. See OHIO REV. CODE ANN. § 4715.22(C)(9).

²⁰ See OHIO REV. CODE ANN. § 4715.22(D) (the dental hygienist’s services must be “in accordance with the dentist’s written treatment plan”).

²¹ See OHIO REV. CODE ANN. § 4715.22(E).

²² Proposed Sec. 4715.22(A)(1), (E) (allowing dental hygienists to provide “dental hygiene services to a patient when a dentist is not physically present,” even though the dentist has not “examined, diagnosed, or provided treatment planning for the patient . . .”). All proposed statutory sections referred to in this letter are set forth in S.B. 330, Section 1, except for the repeal of certain sections listed in S.B. 330, Section 2. See *infra* note 28.

²³ See Proposed Secs. 4715.22(E), 4715.221 (describing required provisions of a written supervision agreement, including exclusions, limitations or conditions on the services the dental hygienist may provide; the dental hygienist’s agreement to comply with the protocols and standing orders of the supervising dentist; and a description of circumstances requiring the dental hygienist to refer patients to a dentist).

²⁴ See Proposed Sec. 4715.22(E)(5).

²⁵ OHIO REV. CODE ANN. § 4715.22(C)(1).

²⁶ See Proposed Sec. 4715.22(E)(4). Proposed Sec. 4715.22(E) also has the potential to avoid other restrictions in OHIO REV. CODE ANN. § 4715.22(E), such as its limitation of general supervision without a prior examination by a dentist to certain services, including application of fluoride varnish and discussion of general nonmedical nutrition.

²⁷ See OHIO REV. CODE ANN. §§ 4715.36-4715.375.

²⁸ See S.B. 330, preamble; Sec. 2 (repealing certain existing sections, including sections 4715.36, 4715.361-4715.369, 4715.37, 4715.371-4715.375).

²⁹ See OHIO REV. CODE ANN. § 4715.365 (allowing dental hygienists who hold an OHASP permit to provide services at a “facility” when no dentist is present, if certain conditions are met); OHIO REV. CODE ANN. § 4715.36(G) (defining “facility”). In addition to specific locations listed in OHIO REV. CODE ANN. §§ 4715.36(G)(1)-(18), such as state correctional institutions, schools, federally qualified health centers, shelters, and non-profit clinics, OHIO REV. CODE ANN. § 4715.36(G)(19) defines a “facility” as any location “that is an area designated as a dental health resource shortage area . . . and provides health care services to individuals who are medicaid recipients and to indigent and uninsured persons”

³⁰ See OHIO REV. CODE ANN. § 4715.366 (requiring dental hygienists to “attempt to schedule the patient’s appointment with the dentist not later than six months after the completion of the dental hygiene services.”).

³¹ See OHIO REV. CODE ANN. § 4715.362 (application for permit; dentist); OHIO REV. CODE ANN. § 4715.363 (application for permit; dental hygienist); OHIO REV. CODE ANN. § 4715.364 (permit required); OHIO REV. CODE ANN. § 4715.365 (authority under permit); and OHIO REV. CODE ANN. § 4715.372 (adoption of rules; course standards).

³² See Proposed Secs. 4715.70, 4715.71.

³³ See Proposed Sec. 4715.72(B).

³⁴ See Proposed Sec. 4715.72(A).

³⁵ See Proposed Secs. 4715.72(A), 4715.74.

³⁶ See Proposed Sec. 4715.72(B), (C).

³⁷ See *supra* notes 23-24, 26, and accompanying text.

³⁸ See Proposed Sec. 4715.80(B) (“No person shall hold that person’s self out as being able to function as a dental hygienist therapist . . . without current, valid licenses to practice both dental therapy and dental hygiene issued pursuant to this chapter.”).

³⁹ See Proposed Secs. 4715.25(B)(3) (application of dental therapy continuing education requirements to maintenance of dental hygiene license); 4715.76(B)(3) (application of dental hygiene continuing education requirements to maintenance of dental therapy license). By contrast, other states that require applicants for licensure as a dental therapist to be licensed as a dental hygienist may not require maintenance of both licenses. See, e.g., 26 VT. STAT. ANN. TIT 26, § 611 (“a licensed dental therapist . . . shall not be required to maintain his or her dental hygienist license”).

⁴⁰ See Comment from FTC Staff to Valencia Seay, *supra* note 14 (regarding removal of direct supervision requirements for dental hygienists); Nat’l Governors Ass’n, *The Role of Dental Hygienists in Providing Access to Oral Health Care* 4-5 (Jan. 2014), <http://www.nga.org/files/live/sites/NGA/files/pdf/2014/1401DentalHealthCare.pdf>; April V. Catlett & Robert Greenlee, *A Retrospective Comparison of Dental Hygiene Supervision Changes from 2001 to 2011*, 87 J. DENTAL HYGIENE 110 (2013), <http://jdh.adha.org/content/87/3/110.full.pdf> (“direct supervision confines the dental hygienist to a facility where the dentist is physically present”); INST. OF MED., ALLIED HEALTH SERVICES: AVOIDING CRISES 108 (1989) (“The opportunities for hygienist employment outside dental offices today are limited by regulations that require them to work with dentists on site. Thus, populations such as the elderly in long-term care facilities and physically and mentally retarded people in institutions, whose access to care is limited by their lack of mobility, cannot be served by hygienists alone.”). In 2015, the Institute of Medicine became the National Academy of Medicine. See Press Release, The Nat’l Acad. of Scis., Eng’g, & Med., Institute of Medicine to become National Academy of Medicine (Apr. 28, 2015), <http://www.nationalacademies.org/hmd/Global/News%20Announcements/IOM-to-become-NAM-Press-Release.aspx>.

⁴¹ See Comment from FTC Staff to Valencia Seay, *supra* note 14, at 3 (describing how Georgia’s direct supervision requirement resulted in duplication of effort when dentists were available, and exclusion of dental hygienists when dentists were unavailable).

⁴² See *supra* notes 10-11 and accompanying text; Margaret Langelier et al., *Expanded Scopes of Practice for Dental Hygienists Associated with Improved Oral Health Outcomes for Adults*, 35 HEALTH AFF. 2207, 2208 (2016) (because some people lack access to dentists, regulations “requiring a dental visit before being seen by a dental hygienists may be a barrier to receiving preventive care”).

⁴³ Langelier et al., *supra* note 42, at 2211 (from 2001-2014, many states adopted regulatory changes “that reduced the direct supervision required for dental hygienists, most notably in public health settings”); Catlett & Greenlee, *supra* note 40, at 114-15 (45 out of 51 jurisdictions reduced dental hygienists’ supervision requirements from 2001-2011 (as compared to 1993-2000), but Alabama, Georgia, Mississippi, and North Carolina rely on direct supervision and have made little progress in reducing supervision); see also Am. Dental Hygienists’ Ass’n, *supra* note 13.

⁴⁴ See Am. Dental Hygienists’ Ass’n, *Current Direct Access Map* (Apr. 2016), http://www.adha.org/resources-docs/7524_Current_Direct_Access_Map.pdf. The American Dental Hygienists’ Association defines direct access as “the ability of a dental hygienist to initiate treatment based on their assessment of a patient’s needs without the specific authorization of a dentist, treat the patient without the presence of a dentist, and maintain a provider-patient relationship.” *Direct Access*, AM. DENTAL HYGIENISTS’ ASS’N, <http://www.adha.org/direct-access>. See also Doreen K. Naughton, *Expanding Oral Care Opportunities: Direct Access Care Provided by Dental Hygienists in the United States*, 14 J. EVIDENCE-BASED DENTAL PRAC. (SUPPLEMENT) 171 (2014). ADHA classifies Ohio as a direct access state because of the limited direct access under OHIO REV. CODE ANN. § 4715.22(D)(b), which allows dental hygienists to place pit and fissure sealants in schools without the involvement of a dentist; and because of OHASP,

even though most practitioners do not participate in the program. See Am. Dental Hygienists' Ass'n, *Direct Access States* (Dec. 2016), http://www.adha.org/resources-docs/7513_Direct_Access_to_Care_from_DH.pdf.

⁴⁵ According to the Ohio State Dental Board, only 31 dentists and 98 dental hygienists held Oral Health Access Supervision Permits in FY 16. At that time there were 7,088 licensed dentists and 8,377 dental hygienists in Ohio. Thus, only about 0.4% of Ohio dentists and 1.2% of hygienists held access supervision permits in FY 16. See Ohio State Dental Bd., Annual Report, FY 15/FY 16 Biennium 7 (2016), <http://www.dental.ohio.gov/Portals/0/Board/Annual%20Reports/ANNUAL%20REPORT%20Dental%20Board%2008%2018%2016.pdf?ver=2016-09-15-144407-677>. Restrictions on settings for general supervision may have discouraged practitioners from obtaining permits; indeed, the permit requirement itself may have discouraged practitioners from availing themselves of the general supervision options provided by OHASP.

⁴⁶ See Catlett & Greenlee, *supra* note 40, at 114-16; Nat'l Governors Ass'n, *supra* note 40, at 5 (“Typically, states require more supervision in private settings than in public settings. No state requires more stringent oversight in public settings than in private settings.”).

⁴⁷ INST. OF MED. & NAT'L RESEARCH COUNCIL, IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 234-35 (2011).

⁴⁸ In Ohio, 11.2% of the population lives in an area designated as a Dental Care Health Professional Shortage Area (“DCHPSA”), and the percent of need met by dentists is only 38.2%. For the United States as a whole, 15.4% of the population lives in a DCHPSA, and the percent of met need is similar to Ohio's, 38.9%. See *Dental Care Health Professional Shortage Areas (HPSAs)*, KAISER FAMILY FOUND. (last updated Jan. 1, 2017), <http://kff.org/other/state-indicator/dental-care-health-professional-shortage-areas-hpsas/>; Kaiser Comm'n on Medicaid & the Uninsured, Kaiser Family Found., *Oral Health in the US: Key Facts 2* (June 2012), <http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf> (based on 2010 census data at <http://www.census.gov/2010census/data/>). In addition, the oral health workforce is not well distributed, so many counties are dental professional shortage areas. See *infra* note 57.

⁴⁹ Dental hygienists earn considerably less than dentists. See INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 47, at 87 (mean annual wage of \$143,000 for salaried general dentists, compared to \$66,500 for dental hygienists). Requirements for direct supervision and examination of patients by a dentist could undercut the cost savings that would otherwise arise from the use of a dental hygienist because they entail payment for a dentist's services. See *infra* note 62 and accompanying text (discussing supervision and cost savings from obtaining care from dental therapists and APRNs).

⁵⁰ See, e.g., Brian E. Whitacre, *Estimating the Economic Impact of Telemedicine in a Rural Community*, 40 AGRIC. & RES. ECON. REV. 172, 176-78 (presenting transportation savings and savings from not missing work arising from local (virtual) availability of a health care provider in a rural community). Savings on patients' transportation costs may reduce state health care costs, because state Medicaid programs cover transportation and related travel expenses necessary for treatment. See 42 C.F.R. § 440.170; OHIO ADMIN. CODE 5160-15-01, 5160-15-11 (2016). See also *infra* notes 58-59 (discussing how supervision of an affiliated practitioner can improve the convenience of care at times and locations where a dentist is not available).

⁵¹ See Catlett & Greenlee, *supra* note 40, at 110-11, 116; Nat'l Governors Ass'n, *supra* note 40, at 4.

⁵² Langelier et al., *supra* note 42, at 2213.

⁵³ See Nat'l Governors Ass'n, *supra* note 40, at 10 (2014). One study suggests that even without any supervision, dental hygienists' preventive care is “at least as good as hygiene care provided with dentists' supervision,” and does not “increase the risk to the health and safety of the public or pose an undue risk of harm to the public.” James R. Freed, Dorothy A. Perry & John E. Kushman, *Aspects of Quality of Dental Hygiene Care in Supervised and Unsupervised Practices*, 57 J. PUB. HEALTH DENTISTRY 68, 74 (1997). See also Catlett & Greenlee, *supra* note 40, at 111 (requiring the physical presence of a dentist is unnecessary for most dental hygiene care because “there is little possible danger in most dental services provided”).

⁵⁴ INST. OF MED. & NAT'L RESEARCH COUNCIL, *supra* note 47, at 234.

⁵⁵ See FTC STAFF, POLICY PERSPECTIVES, *supra* note 7, at 29-31 (discussing various ways in which required collaboration agreements establish physicians as gatekeepers who control APRNs' access to the market and the terms on which they may practice).

⁵⁶ See *supra* note 44 and accompanying text. Although many states require supervision of APRNs pursuant to collaboration agreements with physicians, we have suggested that state legislators and regulators “carefully consider whether the goals of collaboration and coordination can be achieved via less restrictive alternatives.” See FTC STAFF, POLICY PERSPECTIVES, *supra* note 7, at 34-35.

⁵⁷ See *supra* note 48. Thirty-six Ohio counties (out of a total of 88) have been designated as countywide geographic or special population Dental Health Professional Shortage Areas, while many other counties have community or facility DHPAs within them. See Ohio Dep't of Health, *Dental Health Professional Shortage Areas Map* (Sept. 28, 2016), https://www.odh.ohio.gov/-/media/ODH/ASSETS/Files/ohs/oral-health/HPSA-Web-map-9_2016.pdf.

⁵⁸ See, e.g., FTC STAFF, POLICY PERSPECTIVES, *supra* note 7, at 20-27; MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY, EARLY IMPACTS OF DENTAL THERAPISTS IN MINNESOTA (2014), www.health.state.mn.us/divs/orhpc/workforce/dt/dtlegisrpt.pdf (reporting on the use of dental therapists in Minnesota to improve access to care for underserved populations, increase the quality and convenience of care, and reduce costs); Jane Koppelman et al., *Expanding Where Dental Therapists Can Practice Could Increase Americans' Access to Cost-Efficient Care*, 35 HEALTH AFF. 2200, 2205 (2016) (“Dental therapy has the potential to provide cost-effective care in both safety-net and private practice settings, and thus it may thrive in a climate in which health care providers must deliver on access and outcomes.”); Heather Taylor, *Parallels between the Development of the Nurse Practitioner and the Advancement of the Dental Hygienist*, 90 J. DENTAL HYGIENE 6, 7 (2016) (like the introduction of the nurse practitioner, dental hygiene-based workforce models, including dental therapy, are being developed to address issues of access to care and costs).

⁵⁹ See, e.g., MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY, *supra* note 58, at 22 (a rural clinic must close if its one dentist isn't available, because a dental therapist cannot provide certain services without a supervising dentist on site; if the clinic had an advanced dental therapist (who can provide all services under the general supervision of an off-site dentist), the clinic could remain open); *supra* notes 40-42 and accompanying text. See also TRACY A. HARRIS, INST. OF MED., THE U.S. ORAL HEALTH WORKFORCE IN THE COMING DECADE: WORKSHOP SUMMARY 86, 87 (2009) (summary of presentation of Dr. Paul Glassman, Univ. of the Pacific School of Dentistry) (“To better accommodate all members of society, services need to be delivered in community locations where people work, live, plan, and attend school. Delivery of many oral health services do not require a fully equipped dental operator . . .”).

⁶⁰ See, e.g., MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY, *supra* note 58, at 20 (reporting that the personnel costs of employing a dental therapist are roughly half as much as a dentist, ranging from \$35,000 - \$62,000 less than a dentist); Koppelman et al., *supra* note 58, at 35 (a Minnesota dental therapist's annual salary is about \$62,000 less than a dentist's).

⁶¹ Burton L. Edelstein, *Examining Whether Dental Therapists Constitute a Disruptive Innovation in U.S. Dentistry*, 101 AM. J. PUB. HEALTH 1831, 1832 (2011). See also Tryfon J. Beazoglou et al., *Impact of Dental Therapists on Productivity and Finances: II. Federally Qualified Health Centers*, 76 J. DENTAL EDUC. 1068, 1071 (2012) (even assuming that a dental therapist's wage is half that of dentist, the estimated reduction in costs from employing dental therapists is about 6 percent, because dentists are responsible for only about 25% of clinic services and dental therapists would account for 17% of children services); MINN. DEP'T OF HEALTH & MINN. BD. OF DENTISTRY, *supra* note 58, at 20-21 (explaining that employment of dental therapists does not immediately save money for state public programs because the reimbursement rates for their services are the same as those for dentists, but that the “savings resulting from the lower costs of dental therapists are allowing clinics to expand capacity to serve more underserved and public program patients”).

⁶² See Comment from FTC Staff to CODA (Dec. 2, 2013), *supra* note 17. Similarly, FTC staff has concluded that excessive supervision requirements may increase health care costs and prices for care provided by APRNs, who tend to be low-cost providers. See FTC STAFF, POLICY PERSPECTIVES, *supra* note 7, at 27-28.

⁶³ See *supra* notes 53-56 and accompanying text.

⁶⁴ See, e.g., Marko Vujicic et al., *Dental Care Presents the Highest Level of Financial Barriers, Compared to Other Types of Health Care Services*, 35 HEALTH AFF. 2176 (2016) (“irrespective of age, income level, and type of insurance, more people reported financial barriers to receiving dental care, compared to any other type of health care”); Elizabeth A. Mertz, *The Dental-Medical Divide*, 35 HEALTH AFF. 2168, 2170 (2016).

⁶⁵ FTC staff raised similar concerns about restricted access to practitioners with respect to a West Virginia bill that would have allowed only APRNs to obtain a prescribing license only if they practiced in a health professional shortage area. See Comment from FTC Staff to Kent Leonhardt, State Senator, West Virginia Senate 6-7 (Feb. 2016), https://www.ftc.gov/system/files/documents/advocacy_documents/ftc-staff-comment-senate-west-virginia-concerning-competitive-impact-wv-senate-bill-516-regulation/160212westvirginiacomment.pdf. FTC staff considered the limitation on APRN practice setting unduly restrictive even though even though it was limited to a particular function, prescribing. See *id.* S.B. 516 did not pass.

⁶⁶ See *id.* at 7 (“APRNs – and institutional providers employing APRNs – may be discouraged from securing the required [prescribing] license, and entering underserved areas, if a license does not permit any practice, however limited, outside an HPSA.”).

⁶⁷ See, e.g., Kavita Mathu-Muju et al., *Current Status of Adding Dental Therapists to the Oral Health Workforce in the United States*, 3 CURRENT ORAL HEALTH REP. 147 (2016); Koppelman et al., *supra* note 58, at 35 (Although about a dozen states have considered licensure of dental therapists, only three, Minnesota, Maine, and Vermont enacted such legislation; only Minnesota has practicing dental therapists, a total of 58). In addition, Alaska has 35 practicing dental therapists through the federal Community Health Aide Program, which is limited to indigenous Alaska Natives. *Id.*

⁶⁸ See *National Health Service Corps*, HEALTH RES. & SERVS. ADMIN., <https://nhsc.hrsa.gov/index.html> (offering scholarships to students in accredited schools (physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants); and loan repayments for a broader set of practitioners, including dental hygienists and various mental health practitioners as well as physicians, dentists, nurse practitioners, certified nurse midwives, and physician assistants).

⁶⁹ OHIO REV. CODE ANN. §§ 3702.96-3702.967.

⁷⁰ Of the three states that provide for licensure of dental therapists, two (Minnesota and Maine) require them to practice in underserved settings, while Vermont does not have such a restriction. See MINN. STAT. § 105A.105, subd. 2, 8; ME. REV. STAT. tit. 32, § 18377(3)(A); VT. STAT. ANN. tit. 26, §§ 611-617.

⁷¹ See, e.g., Ann Battrell & Ann Lynch, *Representing Dental Hygienists*, PERSP. ON MIDLEVEL PRACTITIONER, Oct. 2016, at 28 (Supplement to Dimensions of Dental Hygiene), http://www.dimensionsofdentalhygiene.com/2016/perspectives_2016/policy_and_regulation/Representing_Dental_Hygienists.aspx (ADHA developed policy supporting dental therapy as a career option for dental hygienists); See Langelier et al., *supra* note 42, at 2211 (explaining that dental hygiene therapy builds on dental hygienists’ foundational competencies, skills and functions); Colleen M. Brickle et al., *Minnesota Extends Oral Healthcare Delivery to Impact Population Health*, 16 J. EVIDENCE-BASED DENTAL PRAC. (SUPPLEMENT) 68, 69 (2016) (in addition to improving public health, licensure of dental therapists “brings new opportunities to the dental hygiene profession”).