ADA American Dental Association®
America's leading advocate for oral health

211 East Chicago Avenue
Chicago, Illinois 60611

T 312.440.2500
F 312.440.7494
www.ada.org

November 24, 2008

VIA ELECTRONIC MAIL AND FEDERAL EXPRESS

The Honorable William E. Kovacic
Chairman, Federal Trade Commission
600 Pennsylvania Avenue, NW
Washington, DC 20580

Re: Emerging Health Care Competition and Consumer Issues – Comment, Project No. P083901

Dear Chairman Kovacic:

The American Dental Association (ADA) is pleased to submit these comments for inclusion in the record for the Federal Trade Commission (FTC) workshop on the Competitive Significance of Health Care Quality Information. The comments are submitted in response to, and conformity with, the September 2008 Federal Register Notice issued by the Commission.[1]

I. ADA Background and Objectives

The ADA is America's leading advocate for oral health. Established in 1859, the ADA today represents more than 155,000 licensed dentists in the United States. Through its numerous initiatives the ADA supports programs to improve access to high quality dental care for all Americans and to inform all Americans about their oral health.

II. Recommendations for Follow-Up FTC Action

The ADA thanks the Commission for conducting this serious inquiry into the competitive role of health care quality information. We understand that FTC staff will use the information gathered through the workshop to prepare a written report, as well as to make recommendations to healthcare policymakers, including Congress, the Centers for Medicare & Medicaid Services (CMS), and the U.S. Department of Health and Human Services (HHS). With these objectives in mind, we urge the Commission to consider the following recommendations as it moves forward with its work.

A. Avoid One-Size-Fits-All Policy Proposals

Although it is often useful, for the sake of convenience, to use the blanket term "health care provider," it is important to remember that there are significant differences between types of providers and the markets in which they operate. Likewise, the amount of health care quality information available, and they way it is used by patients, providers, and payers, may differ substantially depending on the type of health care service being provided. For example, there are important differences between the way consumers use quality information regarding dental practices and standard primary care physician practices.

---

[1] Public Workshops and Roundtables: Emerging Health Care Competition and Consumer Issues, 73 Fed. Reg. 51,479 (Sept. 3, 2008).

Perhaps the single biggest difference is the way that patients pay for dental care, as opposed to medical care. Much of the workshop discussion was driven by the assumption that, because most patients pay for medical care primarily through insurance, they are not particularly interested in making a cost-for-quality assessment.[2] Rather, though patients are concerned about minimum co-pays and deductibles, after these required payments are made, they tend to make their health care purchasing decisions based on other criteria.

However, this assumption – if it applies at all – is far less applicable to the dental services field. The number of employers providing dental plans is far lower than the number providing insurance for medical care, and the employer-provided plans that exist tend to be far less comprehensive. As a result, dental patients are far more likely to be paying for some or all of the care they receive out-of-pocket, and to have a corresponding strong incentive to seek out the dentist that provides the highest quality care at the lowest price. Unlike medical plans, dental plans have annual caps that usually range from $1000 to $1500. While patients under a medical plan tend to consider their funds unlimited, those under a dental plan know that their funds are limited and, therefore, are concerned with a "cost-for-quality" assessment. Consequently, it would be both unnecessary and unhelpful to sweep up dental practices in umbrella proposals to provide patients with quality assessment surrogates – particularly if those surrogates are insurers.

B. Consider the Widely-Accepted Benefits of Self-Regulation

Before the government intervenes in efforts to control the development and use of health care quality information, we believe that it is important to consider the substantial benefits of voluntary approaches. We believe that such efforts should be the starting point, and that governmental efforts should be regarded only as a supplement, or as a rare substitute in the event experience with self-regulatory efforts clearly proves that they are not serving the needs of health care consumers.

The Commission itself has been a strong and consistent supporter of self-regulatory approaches,[3] the advantages of which are numerous. First and foremost, self-regulation puts specialized decision-making in the hands of industry participants with the greatest expertise.[4] This is particularly important

---

2 *See, e.g.*, Irene Fraser, *Competing on Quality: 6 Barriers to a Healthy Health Care Market* (Oct. 2008), *available at* http://www.ftc.gov/bc/workshops/hcbio/docs/ifraser.pdf.

3 *See, e.g.*, J. Thomas Rosch, Commissioner, Federal Trade Commission, *Self-Regulation and Consumer Protection: A Complement to Federal Law Enforcement*, Remarks before NAD Annual Conference 2008 (Sept. 23, 2008), *available at* http://www.ftc.gov/speeches/rosch/080923Rosch-NADSpeech.pdf; Thomas B. Leary, Commissioner, Federal Trade Commission, *Self-Regulation and the Interface Between Consumer Protection and Antitrust*, Remarks Before the Dewey Ballantine Law Firm (Jan. 28, 2004), *available at* http://www.ftc.gov/speeches/leary/040128deweyballantine.pdf; Robert Pitofsky, Chairman, Federal Trade Commission, *Self Regulation and Antitrust*, Remarks Before the D.C. Bar Association Symposium (Feb, 18, 1998), *available at* http://www.ftc.gov/speeches/pitofsky/self4.htm; Debra A. Valentine, General Counsel, Federal Trade Commission, *Industry Self-Regulation and Antitrust Enforcement: An Evolving Relationship*, Remarks Before the Arison School of Business and the Israeli Antitrust Authority (May 24, 1998), *available at* http://www.ftc.gov/speeches/other/ dvisraelspeech.htm.

4 *See* Rosch, *supra* note 3, at 12.

in the health care field. Even governmental agencies with substantial health policy expertise, such as CMS and HHS, are at a significant disadvantage, compared to providers, in attempting to discern which measures of quality are most helpful to patients in specialized health care fields, including dentistry. Self-regulatory approaches also provide a solution to two of the most significant barriers to successful governmental efforts: resource constraints and strict jurisdiction limitations.[5] Dentists, for example, are likely to devote far greater focus to quality oral health care standards than federal entities charged with overseeing the entire health care sector, and dentists have the freedom and incentive to consider *all* patient concerns – even those that extend beyond a specific statutory mandate.

Such self-regulatory efforts, at least in the dental field, are not mere theoretical prospects, but are already in active development. However, they are still relatively new endeavors that could be adversely affected by untimely government intervention. For example, the ADA is currently discussing an outcomes measure that would entail adoption of an oral health classification system, similar to the system currently used by the U.S. military, based on broadly defined categories of oral health that are represented numerically and recorded at each patient visit. The ADA is also currently discussing an offer from CMS to establish a Dental Quality Alliance. We consequently urge the Commission, in making recommendations in its workshop report, to give significant weight to these ongoing self-regulatory efforts before proposing additional, potentially conflicting, governmental efforts to displace them.

C. Provide Additional Guidance on Antitrust-Compliant Provider Collaborations

Another step that the Commission could take to promote the efficient exchange of more and better health care quality information is to provide additional guidance on antitrust-compliant provider collaborations. The FTC made major progress in this area in 1996 with the publication of the *Health Care Statements*.[6] In particular, the clarification in Statement 8 that joint contracting may be permissible where a provider collaboration implements active and ongoing programs to "control costs *and ensure quality*" appeared to provide a strong incentive for providers to prioritize the development of enforceable "best practices" with respect to quality.[7] Over a decade of experience, however, has demonstrated that additional, more precise, guidance is needed.

The subsequent guidance provided by the FTC's advisory opinions has been helpful, but has not resolved all outstanding issues. The *MedSouth* opinion's[8] approval of a joint contracting proposal, based on clinical integration alone, was a step in the right direction. Recognition of the fact that clinical practice guidelines, tied to measurable and enforceable performance goals, have significant potential to reduce cost and increase quality, and therefore justify related joint contracting, appeared to open the door to widespread adoption of independent practice association (IPA) models. Likewise,

---

5 *See id.* at 11-14.

6 U.S. DEP'T OF JUSTICE & FED. TRADE COMM'N STATEMENTS OF ANTITRUST ENFORCEMENT POLICY IN HEALTH CARE (1996).

7 *Id.* at Statement 8 (emphasis added).

8 FTC Staff Advisory Opinion Letter to MedSouth, Inc. (Feb. 19, 2002), *available at* http://www.ftc.gov/bc/adops/medsouth.shtm.

the more recent clarification, in the *Greater Rochester Independent Practice Association* opinion,[9] that IPAs remain an antitrust-compliant alternative – despite the rise of insurer- and employer-driven efforts (*i.e.*, non-provider based models) to reduce cost and increase quality – was most welcome. Nevertheless, substantial uncertainty regarding legality of certain IPA practices continues to dampen enthusiasm for these arrangements among providers, including dentists.

Two clarifications in particular would substantially reduce this uncertainty. First, the Commission could clarify the respective roles of IPA size and exclusivity in its market power analysis. The FTC's current guidance suggests that only an IPA that consists of less than 30% of the providers in a particular market *and* is the non-exclusive bargaining agent of the participating providers would not trigger an antitrust investigation. This belt-and-suspenders approach is overly restrictive and, not surprisingly, has discouraged greater use of the IPA model for dentistry and many other health care providers. To address this situation, the Commission should consider: (1) permitting a higher market share threshold where the IPA is a non-exclusive bargaining agent, and/or (2) removing the non-exclusivity requirement where IPA participation is under the 30% threshold. Both moves would more carefully calibrate the FTC's guidance to the actual level of the potential competitive threat presented. They would also constitute a more realistic response to the bargaining power disparity that health care providers face when contracting with most insurers.

Second, the Commission could clarify the circumstances under which joint contracting is sufficiently necessary, and reasonably related, to enforceable, performance-driven clinical practice guidelines. After the market power assessment, this is the most critical aspect of any antitrust review of an IPA arrangement, yet it is also the area in which the FTC's guidance has been least clear. The Commission has acknowledged that joint contracting *may* permit an IPA to properly incentivize its members, by enabling it to reward those providers that meet performance goals and make appropriate investments of time and effort in implementing the IPA's procedures, but it has not provided clear guidance on when joint contracting clearly is, or is not, related to these procompetitive benefits. Providing such guidance would go a long way toward reassuring providers that participation in an IPA is a potential quality-enhancing solution, rather than an invitation to a costly antitrust investigation.

D. Consider Using the Commission's Consumer Protection Authority to Examine the Risks of Insurer-Driven Provider Rating Efforts

Proposals to "rate" providers, according to a variety of quality standards, are often mentioned as a potential means of using quality information to inject competition into the health care field. The ADA acknowledges that, if such a rating system were administered transparently, and was based on a scientifically well-grounded set of underlying standards, developed with substantial provider input, it could substantially assist both patients and payers in making well-informed decisions. However, if such a rating system were developed and implemented exclusively by insurers, we believe that its utility would be undermined by the inherent conflict of interest. Indeed, given the potential for substantial consumer harm, we urge the Commission to be vigilant for ratings that stray from their claimed objective or lack substantiation for their reported findings.

Concerns regarding potential consumer deception are not merely theoretical. As the Healthcare Industry Taskforce convened by the New York Attorney General's Office discovered, programs

---

[9] FTC Staff Advisory Opinion Letter to Greater Rochester Independent Practice Association, Inc. (Sept. 17, 2007), *available at* http://www.ftc.gov/bc/adops/gripa.pdf.

insurers market to consumers as providing guidance on the quality of care are often used to steer patients to the cheapest, though not necessarily the best, providers.[10] This is hardly surprising given the insurers' financial incentives. In response to the Attorney General's investigation, a number of the nation's largest health plans – including Wellpoint, UnitedHealthcare, and Aetna – have agreed to apply "model reforms," developed in conjunction with the American Medical Association, to their provider ranking programs.[11]

In light of the practices identified by the Healthcare Industry Taskforce, we urge the Commission to use its law enforcement authority to address other instances of consumer deception resulting from these insurer-driven programs. We also urge the Commission to consider, both when drafting its workshop report and making recommendations to other health care policymakers, the key elements of the "model reforms" to provider rating programs. These include ensuring that quality ratings are based on quality, not cost. By the same token, any rating that takes cost into account should not be represented as a quality rating. Cost-based ratings should identify the extent to which the metric is based on cost, disclosing to both patients and providers how programs are designed and ratings determined, and providing for oversight by an independent ratings examiner.[12]

III. Conclusion

The ADA appreciates the opportunity to participate in the FTC's workshop and to submit these written comments. We look forward to the opportunity to work with FTC staff to address these important issues as the Commission's inquiry moves forward.

Very truly yours,

Tamra S. Kempf
Chief Legal Counsel

TSK/tel
cc: Dr. John S. Findley
Dr. Ronald L. Tankersley

---

10 NY OAG Press Release, *Attorney General Cuomo Calls on Health Care Companies to Halt Planned Doctor Ranking Programs* (Oct. 18, 2007), *available at* http://www.oag.state.ny.us/media_center/2007/oct/oct18a_07.html.

11 NY OAG Press Release, *Attorney General Cuomo Announces Doctor Ranking Agreement with UnitedHealthcare* (Nov. 20, 2007), *available at* http://www.oag.state.ny.us/media_center/2007/nov/nov20b_07.html.

12 *Id.* See also American Medical Association, Comments in FTC Workshop on the Competitive Significance of Health Care Quality Information 2-6 (Sept. 30, 2008), *available at* http://www.ftc.gov/os/comments/healthcarecompissues/537778-00004.pdf.