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VIA ON-LINE SUBMISSION: <https://ftcpublic.commentworks.com/ftc/healthcareworkshop>

Federal Trade Commission
Office of the Secretary
Room H-113 (Annex X)
600 Pennsylvania Avenue, NW
Washington, D.C. 20580

Re: HEALTH CARE WORKSHOP, PROJECT NO. P131207

Comments by Dentists for Oral Health Innovation

To Whom It May Concern:

In response to the request by the Federal Trade Commission ("FTC")'s Notice of Public Workshop and Opportunity for Comment, published on February 24, 2014, Federal Register Vol. 79, No. 36, p. 10153-56, Dentists for Oral Health Innovation ("DOHI") desires to file the following comments in support of the FTC's work with the Health Care Workshop, Project No. P131207 (the "Health Care Workshop").

Dentists for Oral Health Innovation ("DOHI") is a coalition of over 5,000 dentists who are committed to expanding access to affordable, quality dental care for patients through the use of advanced models and methods. DOHI represents dentists nationwide that include solo practitioners, dentists operating in group practices and dentists who contract with dental support organizations ("DSOs"). A DSO is an entity that provides non-clinical services to assist dental practices with their operations which enables those dentists to focus on the delivery of high-quality, cost-effective dental care to their patients. Many of DOHI's members choose to affiliate with a DSO to avail themselves of those very benefits and, as such, can speak first hand to the scope of those benefits. Today, DSOs support an estimated 8,000 licensed dentists practicing in over 5,000 dental practices who in turn serve more than 27 million patients each year across the country.

DSOs: What they are and what they do.

DSOs are not engaged in the clinical practice of dentistry; they merely provide the administrative support that dental practices require, such as billing services, financing, supply procurement, assistance in the areas of marketing, recruiting, human resources and other non-clinical services.¹ These services are no different than those provided for decades by support firms to other medical providers, such as physicians, optometrists and other health professionals. The support services provided by DSOs to dentists, therefore, are the logical evolution from the traditional dental practice where the dentist, in addition to providing his/her practice's clinical services to patients, must also either himself/herself personally, or through hired employees, conduct the non-clinical activities of the practice. DSOs alleviate the daily demands of being a small business-person and allow the dentist to

concentrate on what he/she went to dental school for ... to practice dentistry. Since DSOs are staffed with personnel who are experienced in all areas of the non-clinical aspects of a dental practice, and because they provide their services and can spread their costs over often hundreds of dental practices, they can conduct the non-clinical aspects of a dental practice far more efficiently than can a solo-practitioner or small group dental practice that must rely on more traditional methods to manage these matters.

How DSOs Provide for a More Efficient Market in the Delivery of Dental Services by Assisting in the Removal of Structural Barriers to Entry for Dentists.

1. Costs and Commitment of Opening or Operating a New Dental Practice.

- a. Issues for Dentists. A typical dental practice costs \$400,000 to \$800,000 or more to build out, equip and supply (exclusive of the costs to rent or purchase space for the dental office). Recent industry movement, and governmental requirements, to newer technological needs (such as digital x-rays and records, etc.) have only served to increase the cost to start and operate a dental practice.

Many new dentists are graduating with student loans in excess of \$250,000, and at an age when they commonly may be looking to start a family. When the costs of a home mortgage, car loan(s) and student loans are factored in, few lenders are willing to extend the \$400,000 to \$800,000 in additional financing necessary to start a dental practice. That leaves the recent graduate with few career options. Working as an associate in another dentist's practice, for a charitable organization, or in the military may not be viable for every dentist. And working as an associate dentist does not increase competition in a community for dental services.

In addition, there are many skilled clinicians who may have opened practices years ago which they, for one reason or another, cannot operate profitably, resulting in the closure of those practices. The dentist often is a skilled clinician who may not have been equally skilled as a small business-person or who, due to his/her practice's cost structures or otherwise, may not have been able to generate enough income from his/her practice to fund all of the debt and practice operation obligations. Much like the recent graduate, these dentists (who may have years of experience) are left with few career options.

According to the American Dental Association, over 46% of the graduating classes of the nation's 65 accredited dental schools were femaleⁱⁱ. A portion of female graduates are interested in dental careers that may vary from the traditional structure of operating full time during normal working hours. For this portion of dentists, the economics of opening and operating a full-scale dental practice can be problematic.

- b. How DSOs Help Dentists Overcome Barriers to Entry. As part of the suite of services typically provided to a dentist when he/she contracts with a DSO, the DSO provides all or a major portion of the funding necessary for the dentist to: 1) secure office space; and, 2) equip and supply, a fully-functional dental practice. In addition, the suite of services provided by the DSO includes all of the non-clinical practice support services necessary to help the dentist make the practice a success. DSOs enable recent graduates, seasoned practitioners and dentists who may be interested in non-traditional office hours to open and

operate their own practices, thereby increasing the number of practices from which consumers may choose to have their dental needs addressed.

2. Access to Dental Care; the Impact of DSOs.

- a. Access to Dental Care. On May 25, 2012, the FTC's Office of Policy Planning, Bureau of Competition and Bureau of Economics sent a joint letter to a Representative in the North Carolina House of Representatives, about the impact of then-pending legislation aimed at restricting the activities of DSOs in North Carolina (the "FTC Letter"). In the FTC Letter, the FTC noted the crises in access to dental care in the United States, as follows:

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

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

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

- b. How DSOs Help to Increase Access to Dental Care. The benefits brought by DSOs to the dentists they support help enable those dentists to increase access to dental care in their communities, in a number of ways:
- i. Additional Practices. As noted above, DSOs provide funding to enable dentists to open their own practices. A good portion of those dentists may not have been able to open their own practices in the absence of DSO funding.

- ii. Increased Efficiencies. DSOs provide their non-clinical support services in a more efficient manner than any small practitioner could on his or her own. Those efficiencies arise in a variety of areas, including: A) the ability to spread the costs of specialized services, both personal and technological, across many supported practices; B) the ability to aggregate supply orders from hundreds of supported practices and obtain quantity pricing on equipment and supplies not available to traditional practitioners; C) the ability to recruit staff nationwide to help meet the needs of the practice on a more immediate basis; D) the ability to access necessary services, when and as needed, rather than having to increase costs by adding non-clinical staff positions; etc.
- iii. Enabling Dentists to Practice Dentistry. It is not uncommon for dentists in traditional practice settings to spend a substantial portion of their work week addressing the non-clinical aspects of their practices. DSOs free dentists from these obligations, thereby allowing the dentist to choose to practice more hours as a dentist, which increases the amount of dental services available to a community.

“Consumers benefit when health professionals can organize their practices in the way they find most efficient, consistent with quality care. Licensed dentists contract with DSOs to obtain a variety of back-office, non-clinical functions, allowing these dentists to focus primarily on the treatment of patients, and less on the business management aspects of running a dental practice.”^{iv}

- iv. Efficient Pricing. The result of the increased efficiencies, and the potential to practice more hours as a dentist rather than as a biller, marketer, accountant, etc., enabling the dentist who is supported by a DSO to offer clinical services at a rate below that of dentists in traditional practices. For example, in 2012 in North Carolina, a state with a much lower percentage of dentists supported by DSOs than in five other comparison states, fees paid by consumers in North Carolina were on average 11% higher than paid by the patients in the five comparison states.^v As further noted by the FTC:

“When licensed dentists contract with DSOs to provide nonclinical services to their dental practices, DSOs appear to increase efficiency and support entry by new dental practices, which may lead to lower prices, expanded access to dental services, and greater choice for dental consumers.”^{vi}

3. Recent Developments in Professional Regulation of Dentists and the Impact on Competition and Access to Care.

Dentists, and the practice of dentistry, are licensed and regulated by the dental boards (or equivalent state body) of each state. Dental Boards members consist of a majority of licensed dentists and may also include a minority of consumer-advocacy or dental hygienist members. Members of these provider-majority boards are often competitors to dentists who contract with DSOs.

The practice of dentistry is typically defined by each state’s dental practice act as well as by regulations promulgated by that state’s respective dental board. Some state statutes include

provisions grounded in the 19th-century “corporate practice of medicine” doctrine that typically defines the practice of dentistry as including the employment of a licensed dentist, but is sometimes expanded to include the “control or management” of a licensed dentist or dental practice by a non-licensed person. Certain elements of organized dentistry have, in recent years, taken action to equate the provision of non-clinical services by a DSO for a dentist as that DSO “controlling” or “managing” the dentist, thereby causing the contracting dentist’s professional license to be at risk, and the DSO to be accused of engaging in the unlicensed practice of dentistry. However, as noted by the FTC in the FTC Letter:

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

As has happened in recent years, several state legislatures have considered legislation, and certain dental boards (at the behest of certain elements within organized dentistry) have considered new regulations, which seek to limit the ability of DSOs to support dentists in their states. Typically, the proposed legislation is grounded in an expansion of the 19th-century corporate practice of medicine doctrine. Some of the legislative proposals have attempted to both subject dentists to disciplinary actions and to criminalize the proposed proscribed behaviors and services, often with the hope that the “chilling effect” alone would work to limit either the number of DSOs willing to operate in such a regulatory environment or, perhaps more likely, the number of dentists willing to risk the loss of their professional licenses to contract with a DSO. While the full scope of proposed legislation and rulemaking in the subject states has not been enacted or promulgated, the effect of these legislative and rulemaking efforts have had the “chilling effect” intended by their sponsors. In certain states where these legislative/rulemaking efforts have occurred, many practitioners are reluctant to consider the support advantages offered by DSOs out of the fears noted above.

DOHI applauds the efforts of the FTC in its Health Care Workshop to find and foster efficient methods of health care competition. DSOs are a key element in assisting the dental profession to solve the very real crisis in dental care. DOHI urges the FTC to promote the very real benefits of the DSO model as a method to increase healthy competition in, and to help dentists provide better access to, dental care.

Very truly yours,

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ⁱ Some DSOs, where permitted by state law, may own dental practices. However, DSOs are not engaged in the clinical practice of dentistry, which can only be practiced by dentists who are licensed and in good standing with the respective state's dental board or equivalent regulatory body.

ⁱⁱ American Dental Association, 2011-12 and 2012-13 *Survey of Dental Education – Report 1: Academic Programs, Enrollment, and Graduates*.

ⁱⁱⁱ Federal Trade Commission Letter to a Representative in the North Carolina House of Representatives, May 25, 2012, p. 3 [hereinafter FTC Letter]

^{iv} *Id.* at 1.

^v Report by Dr. Donald Taylor, Pork Barrel Research, LLC, May 9, 2012, pp 5-6.

^{vi} FTC Letter, p. 5

^{vii} *Id.* at 7.