No. 16-50017

UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

TELADOC, INCORPORATED; TELADOC PHYSICIANS, PROFESSIONAL ASSOCIATION; KYON HOOD; EMMETTE A. CLARK,

Plaintiffs-Appellees,

v.

TEXAS MEDICAL BOARD; MICHAEL ARAMBULA, M.D., Pharm. D., in his official capacity; MANUEL G. GUAJARDO, M.D., in his official capacity; JOHN R. GUERRA, D.O., M.B.A., in his official capacity; J. SCOTT HOLLIDAY, D.O., M.B.A., in his official capacity; MARGARET MCNEESE, M.D., in her official capacity; ALLAN N. SHULKIN, M.D., in his official capacity; ROBERT B. SIMONSON, D.O., in his official capacity; WYNNE M. SNOOTS, M.D., in his official capacity; KARL SWANN, M.D., in his official capacity; SURENDRA K. VARMA, M.D., in her official capacity; STANLEY WANG, M.D., J.D., MPH, in his official capacity; GEORGE WILLEFORD, III, M.D., in his official capacity; JULIE K. ATTEBURY, M.B.A., in her official capacity; PAULETTE BARKER SOUTHARD, in her official capacity,

Defendants-Appellants.

Appeal from the United States District Court
for the Western District of Texas, Hon. Robert Pitman,
Case No. 1:15-cv-343

BRIEF OF TEXAS PROFESSORS SPECIALIZING IN HEALTH LAW AND HEALTH POLICY AS *AMICI CURIAE* IN SUPPORT OF PLAINTIFFS-APPELLEES AND URGING AFFIRMANCE

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that each *amicus curiae* is an individual and, as such, no entity has any ownership interest in them. None of the *amici* are corporations or other forms of business entity. *Amici* have no financial interest in the outcome of this litigation.

/s/ Michael F. Sturley

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IDENTITY AND INTEREST OF AMICI CURIAE[1]

Amici curiae are tenured professors at universities in the state of Texas who specialize in health law or health policy. They have an interest in the proper development of health law and health policy. Their names and affiliations are listed below; affiliations are provided only for purposes of identification.

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[1] Pursuant to Federal Rule of Appellate Procedure 29(c)(5), *amici* affirm that no counsel for a party authored this brief in whole or in part and that no person other than amici or their counsel have made any monetary contributions intended to fund the preparation or submission of this brief. All parties have consented to the filing of this brief.

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SUMMARY OF ARGUMENT

When a majority of a professional licensing board is comprised of active members of the licensed profession, the Supreme Court has instructed lower courts to require active supervision by the state itself before conferring immunity from suit challenging board action under the federal antitrust laws. *North Carolina State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101 (2015) ("*North Carolina Dental*"). The purpose of supervision is to ensure that the board's actions reflect a sovereign state's policy decision to reduce or displace competition, for which the state is politically accountable. Here, there was no such supervision or political accounta-

bility for the restriction the Texas Medical Board ("Board") imposed on telehealth providers, and the district court properly denied the Board's state-action defense.

The outcome of this litigation has national importance beyond telehealth because minimally scrutinized, unsupervised physician self-governance – often by state medical boards – exerts significant drag on the U.S. health care system. The affordability of health care for individuals and society, and therefore the efficiency with which it is produced and delivered, are critical health policy goals. Recent assessments from the Institute of Medicine of the National Academies ("IOM") conclude that the U.S. health care system wastes nearly $1 trillion each year on unnecessary, disorganized, overpriced, badly measured, and sometimes harmful services. One cannot escape the conclusion that the consumer orientation, cost discipline, interoperability, and continuous innovation that are routine in other industries, and that make market competition the desired default position for the private economy, are severely underdeveloped in health care.

Although state licensing boards often justify their actions as "patient protection," it also is indisputable that professional self-regulation is a much less effective guarantor of quality and safety than the medical profession asserts and believes. In two authoritative reports from the early 2000s, the IOM documented systematic failures to deliver care that is safe, effective, patient-centered, timely,

efficient, and equitable, resulting among other things in nearly 100,000 avoidable patient deaths every year.

The public and its elected representatives do not prefer their health care system to spend excessively and perform poorly. Rather, the U.S. health care system is trapped in a web of professional privilege that prevents it from achieving its goals. Unsupervised self-regulation is a significant, often invisible obstacle to building a health care system that meets the public's needs and therefore promotes the state's interests. Physicians aggressively defend their individual and collective authority to serve patients on terms that they themselves establish, even if the result is to increase cost and decrease access to care. The medical profession has enforced its private perception of the public interest for many decades, typically in good faith but limited by preconception, habit, and tunnel vision.

Antitrust law plays an important role in advancing consensus health policy goals regarding affordability, quality, choice, and consumer responsiveness. Moreover, the fact that self-regulation of medical practice by state licensing boards and other professional bodies has been so pervasive argues for more, not less, state oversight of potentially anticompetitive conduct. Without active supervision, many policy choices made by the Board remain unidentified or only vaguely described, rendering it impossible for politically accountable state actors such as the governor or legislature to register their opposition. Only a full-throated super-

vision requirement, as called for by the Supreme Court, can reveal professionally determined constraints on markets as explicit policy options and subject them to meaningful political oversight.

The harm to competition is obvious when a group of competitors meets specifically to fix prices while asserting immunity from antitrust liability. Although a licensing board's unsupervised exclusion of a rival category of providers or its blanket prohibition on a modality of care has effects comparable to a collective refusal to deal, anticompetitive medical self-regulation is often more challenging to disentangle from explicit state law. Yet the cumulative effect of embedding unsupervised private processes – especially those that impede market entry – within a seemingly comprehensive but inadequately specified regulatory framework is to worsen inertia in public policy-making and perpetuate conditions that are both anticompetitive and increasingly inconsistent with democratic preferences.

The sky will not fall if the Texas Medical Board is subjected to active supervision requirements. Substantive antitrust law is well-equipped to distinguish between reasonable and unreasonable restraints on trade, and any socially desirable activities of licensing boards that otherwise might be construed as violations of the Sherman Act can be enacted in legislation or administrative regulation and supervised by bona fide state actors. Some Board limitations on medical practice even

may be procompetitive, facilitating informed consumer choice and ensuring that effective services are delivered as promised.

Moreover, the composition of health professional licensing boards can be sufficiently diversified to reduce the likelihood that physicians or any other single group of licensees can, through either conscious or unconscious bias, subvert bona fide state regulation of medicine and health to serve their own interests. Such a restructuring of licensing board practices not only would avoid the need for active supervision under the *North Carolina Dental* standard, but also would likely result in a more nimble, consumer-oriented, and innovative approach to professional self-regulation.

Therefore, the Board's state action defense should be denied.

ARGUMENT

The public and its elected representatives do not prefer their health care system to spend excessively and perform poorly. Rather, the U.S. health care system is trapped in a web of professional privilege that prevents it from achieving consensus health policy goals. Contrary to the assertions of the appellants and their amici, applying the United States Supreme Court's 2015 decision in *North Carolina State Board of Dental Examiners v. FTC*, 135 S. Ct. 1101 (2015) ("*North Carolina Dental*") to require active state supervision of self-interested medical

board rulemaking is necessary to implement sound health policy and to ensure political accountability for that policy.

Health care regulation is necessary both to protect individuals from unsafe or poor quality medicine and to serve the collective interests of society in preventing and treating disease. The expertise and ethics of physicians and other health professionals are an important resource in these efforts. However, it is increasingly apparent that the paucity of effective checks on physicians' self-regulatory privileges has led the U.S. health care system down a path of unaccountability for poor performance, lack of affordability, and waste.

This case involves the anticompetitive implications of specific rules adopted by the Texas Medical Board (the "Board") with respect to telehealth, prescription medication, and the physician-patient relationship. However, the outcome of this litigation will affect health policy broadly in Texas and beyond. The critical role of market competition in promoting efficiency, innovation, and consumer welfare is widely accepted, and undergirds the federal antitrust laws. As discussed below, applying *North Carolina Dental* to state licensing boards controlled by physicians is an important step in making medical markets more competitive.

Following the issuance of the Supreme Court's decision in *North Carolina Dental*, a long-standing dispute between Teladoc and the Board grew to encompass antitrust litigation as well as administrative litigation. This shift is more than a

tactical move in one case. It accords with a growing recognition among policy-makers that accumulated professional privilege in health care has serious adverse consequences for both private markets and public goals.

I. The Underperforming U.S. Health Care System

To understand the need for greater competition in U.S. health care, and to appreciate the inadequacies of the established regime of professional oversight, one must consider the data. On quality, safety, and particularly efficiency, the existing health care system scores poorly.

A. Poor Quality

In recent decades, the U.S. health care system has been revealed as massively wasteful in economic terms, as well as under-performing in its quality, safety, and responsiveness to users. Beginning in the 1970s, health services research identified substantial, unexpected geographic variations in medical treatment that were not associated with either greater health care needs or superior clinical outcomes.[2] "Best practices" were seldom available, outcomes of care were typically unmeasurable, and clear advances in medical knowledge often took years to diffuse into communities and alter the habits of local physicians.

[2] THE DARTMOUTH ATLAS OF HEALTHCARE, Understanding of the Efficiency and Effectiveness of the Health Care System (2015), http://www.dartmouthatlas.org (visited Sept. 8, 2016).

Subsequent research confirmed and expanded expert understanding of systematic quality lapses in the health care system. Many beneficial treatments were underused, while other expensive, risky therapies were overused. Misuse was also common, resulting in medical errors.[3]

B. Poor Safety

Similar evidence accumulated regarding iatrogenic (physician-induced) injury. This body of research was collected, analyzed, and publicized by the Institute of Medicine of the National Academies ("IOM"), which estimated that medical errors kill 44,000–98,000 hospitalized patients annually.[4] A subsequent study revised this figure upward to 195,000.[5] A recent meta-analysis in the *Journal of Patient Safety* concluded that "preventable harm to patients" causes more than 400,000 premature deaths each year, making medical error the third leading cause of death in the United States.[6]

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[3] Mark R. Chassin, Robert W. Galvin, and the National Roundtable on Health Care Quality, *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality*, 280 JAMA 1000 (1998).

[4] INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM (Linda T. Kohn ed., 1st ed. 2000).

[5] Patient Safety in American Hospitals, HealthGrades (2004), http://www.providersedge.com/ehdocs/ehr_articles/Patient_Safety_in_American_Hospitals-2004.pdf (visited Sept. 8, 2016).

[6] John T. James, *A New, Evidence- Based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122 (2013).

C. Enormous Waste

Poor quality and safety are not the result of the U.S. spending too little on health care, which at over $3 trillion annually eclipses most sectors of the economy and far exceeds on a per capita basis spending in any other country.[7] To the contrary, underperformance adds substantially to expense, both directly and in its opportunity costs for scarce private and public resources.

The IOM has attributed over $750 billion each year to waste.[8] Of this amount, an estimated $210 billion reflects unnecessary services, including overuse not justified by scientific evidence, discretionary use beyond established benchmarks, and unnecessary choice of higher-cost services. The IOM identified another $130 billion in inefficiently delivered services, including medical errors, preventable complications, fragmented care, unnecessary use of higher-cost providers, and operational inefficiency at care delivery sites. Excess administrative costs accounted for $190 billion, missed prevention opportunities for $55 billion, and fraud for $75 billion.[9]

The IOM's final category, amounting to $105 billion in annual waste, is "Prices That Are Too High" – meaning that they exceed competitive

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[7] David Squires & Chloe Anderson, U.S. Health Care from a Global Perspective (Commonwealth Fund, Oct. 8, 2015), http://www.commonwealthfund.org/publications/issue-briefs/2015/oct/us-health-care-from-a-global-perspective (visited Sept. 8, 2016).

[8] INSTITUTE OF MEDICINE, BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 101–02 (Mark Smith et al. eds., 2012).

[9] *See id.*

benchmarks.[10] Considerable research has suggested that high and arbitrary prices rather than excessive utilization of care are primarily responsible for the United States' aberrantly large medical expenditures compared to other countries.[11] Relatedly, physicians in the United States earn more than their counterparts abroad.[12]

II. Knowing Where To Go And How To Get There

These long-established failings of the U.S. health care system have generated a strong consensus on improving it. The pursuit of "value-based health care" is now a focus of American health policy, with the phrase achieving broad usage and the concept generating surprising political consensus.[13] The pursuit of value can only be successful with active competition that generates innovations capable of meeting the needs of individuals and communities.

Clear answers have emerged to two key questions: "What should the system seek to become?" and "How should it make progress toward those objectives?" In

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[10] *See id.*

[11] Gerard F. Anderson et al., *It's the Prices, Stupid: Why the United States Is So Different from Other Countries*, 22 HEALTH AFF. 89 (2003); Erin Fuse-Brown, *Irrational Hospital Pricing*, 14 HOUS. J. HEALTH L. & POL'Y 11 (2014).

[12] Miriam J. Laugesen and Sherry A. Glied, *Higher Fees Paid To US Physicians Drive Higher Spending For Physician Services Compared To Other Countries*, 30 HEALTH AFF. 1647 (2011).

[13] U.S. Dep't of Health and Human Services, Better, Smarter, Healthier: In Historic Announcement, HHS Sets Clear Goals and Timeline for Shifting Medicare Reimbursements from Volume to Value (Jan. 26, 2015), http://www.hhs.gov/news/press/2015pres/01/20150126a.html (visited Sept. 8, 2016).

a book-length report, the IOM succinctly stated the six core characteristics of a high-performing health care system:[14]

- Safe: avoiding injuries to patients from the care that is intended to help them.
- Effective: providing services based on scientific knowledge to all who could benefit, and refraining from providing services to those not likely to benefit.
- Patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions.
- Timely: reducing waits and sometimes harmful delays for both those who receive and those who give care.
- Efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy.
- Equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.

[14] INSTITUTE OF MEDICINE, CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY 83 (2001).

The accepted path to improvement is the "Triple Aim," which is the brain-child of Harvard pediatrician Donald Berwick and the Institute for Healthcare Improvement that he founded. The "Triple Aim" consists of the following: (1) Improving the patient experience of care (including quality and satisfaction), (2) improving the health of populations, and (3) reducing the per capita cost of health care.[15] The Triple Aim seeks to address overinvestment in specialized services and concomitant neglect of primary care and prevention. A well-regulated health care market would pursue the Triple Aim through active competition on quality and efficiency, but these objectives are rarely a major focus of licensing boards with vested interests in the status quo.

In addition to integrating individual and population health, the Triple Aim altered the prevailing wisdom in health policy in two important respects. First, it made the crux of the debate over health care spending about improving productive efficiency rather than rationing care. Second, and relatedly, it emphasized incremental improvement, not seeking a definitive political settlement regarding trade-offs among access, cost, and quality. Both of these insights increase the importance to health policy of active competition among providers, particularly the development of new modalities of care that are more accessible and more widely distributed through communities.

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[15] Institute for Healthcare Improvement, IHI Triple Aim Initiative (2015), http://www.ihi.org/Engage/Initiatives/TripleAim/pages/default.aspx (visited Sept. 8, 2016).

Moreover, as two leading experts in health care management state: "There is no longer any doubt about how to increase the value of care."[16] The standard tool-kit for pursuing value includes measuring costs and outcomes, expecting payment only for successful care, building "integrated practice units," and embracing health information technology. Successfully launching these innovations depends critically on effective competition in the marketplace.[17]

III. But Not Being There Yet Because Of Physician Self-Governance

A third question about health system improvement is asked less frequently. If the destination and path to a better health care system are clearly established, why has travel been so slow? More to the point, why are we not already there? The former editor-in-chief of the policy journal *Health Affairs* has observed: "One eternal mystery of US health care is why patients and payers have been loath to demand attributes they take for granted in other sectors of the economy, such as convenience, price transparency, and reasonable costs."[18]

The answer lies largely in a century of accumulated legal deference to the medical profession. Physicians are the masters of the health care universe, with

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[16] Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, 91 HARV. BUS. REV. 50 (2013).

[17] MICHAEL E. PORTER & ELIZABETH O. TEISBERG, REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS (2006).

[18] Susan Dentzer, *It's Past Time to Get Serious About Transforming Care*, 32 HEALTH AFF. 6, 6 (2013).

their ordering and referral behavior accounting for roughly two-thirds of national health expenditures. Laws protect the public from individuals and therapies not ordered or administered by physicians, though in so doing they discourage self-help. Laws fund physicians' tools and defend their quality, both directly and by assuring insurance coverage for physician-recommended treatment. Laws insulate physicians from corporate control. Laws mediate disputes between physicians and patients. Laws apply medical criteria to many ethical issues.

In all these areas, society delegates substantial authority and discretion to the medical profession through organizations such as licensing bodies, medical specialty societies, and the Joint Commission.[19] Society has justified this approach in terms of physicians' scientific power to heal and their ethical duty not to harm. Deference to the medical profession is an accreted policy choice that has developed over more than a century of often reactive, decentralized legal change. Unfortunately, it has foreclosed other options and brought a strong sense of path dependence to health system governance that is increasingly at odds with current health policy priorities such as value-based care and the Triple Aim.

North Carolina Dental obligates, and empowers, states to articulate the terms of physician self-regulation through professional licensing boards, restrict

[19] Formerly called the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), the Joint Commission is a non-profit organization chartered by medical, surgical, and hospital associations that reviews and accredits health care facilities, including eligibility for payment by the Medicare program.

anti-competitive practices that do not reflect explicit state policy, and restore a default position based on market competition as defined and defended by the antitrust laws. Shielded from competition but spared direct public control, medical ethics has proved inadequate as a basis for either harnessing the industrial power of the health care system or effectively serving the poor. Instead, as national wealth grew and medical science improved, the effect of deference has been to promote extravagance and disorganization while neglecting both population health and access to services for patients who cannot afford conventional medical care or who find it geographically inaccessible.

Deference to the medical profession contemplates a single physician serving a single, typically insured patient. It does not emphasize organization, rarely acknowledges scarcity, and routinely tempts physicians to elevate (and indeed to rationalize elevating) self-interest over the common good. The fact that the American public has rejected a socialized health care system with strong central budgetary controls increases the temptation for self-enrichment through unsupervised collective professional activity and magnifies the potential economic loss both to individual buyers of health care and to taxpayers who subsidize care for the poor and elderly.

In addition to compromising the performance of acute and complex care, medical self-regulation has stunted the development of a vast potential domain of

"upstream health." The United States is in the throes of an epidemic of obesity and chronic disease: 35% of American adults are obese, and 45% have diabetes, cardiovascular disease, or a similar condition.[20] Instead of focusing on "patients" who have been separated from their lives and communities in order to undergo diagnosis and treatment in hospitals and clinics controlled by physicians, population health can be advanced more efficiently and effectively by also enabling people to maintain their health and receive basic services in the course of their daily activities.

This approach to basic health and health care invites the emergence of a new body of "upstream health law," which cannot happen absent close scrutiny by government of the terms of professional-self regulation.[21] If the upstream realm were liberated to compete with conventional services, discrete episodes of dyadic care would be supplemented by less well-defined, often asynchronous encounters. De facto physician control over care would give way to more widely distributed information and more diffuse authority. Fortress-like hospitals would be largely replaced by community-based providers and fluid enterprises offering mobile and virtual services. Online price brokerages and ordinary consumer financing vehicles would complement traditional health insurance. And medical equipment

[20] INSTITUTE OF MEDICINE, LIVING WELL WITH CHRONIC ILLNESS: A CALL FOR PUBLIC HEALTH ACTION (2012), http://www.nap.edu/read/13272/chapter/1 (visited Sept. 8, 2016).

[21] William M. Sage & Kelley McIlhattan, *Upstream Health Law*, 42 J.L. MED. & ETHICS 535, 540–41 (2014).

designed to be used only by or on the authority of physicians in conventional care settings would be diversified to include home, portable, and implantable technologies. For the most part, these developments run counter to the interests, and often are beyond the capacity, of the organized medical profession and the hospitals and insurance enterprises to whom physicians channel business.

Physician-imposed barriers to market entry and innovation, often enforced by professional licensing boards, are among the most pernicious practices from a health policy perspective.[22] Medical boards set standards for licensure and impose discipline on licensees who violate their dictates, while unlicensed practice remains a criminal act. Entry barriers erected collectively by physicians not only deter novel approaches from new directions, whether telehealth or "upstream" care modalities, but also discourage existing competitors from adopting practices introduced to the market by disruptive innovators. Drawing an example from outside health care, commercial taxi services in many cities are responding to competition from ride-sharing companies by instituting similar practices that improve convenience and reduce cost.

Powerful medical licensing boards controlled by physicians have attracted criticism for decades. Milton Friedman famously wrote in 1962, "I am . . . per-

[22] Aaron Edlin & Rebecca Haw, Cartels by Another Name: *Should Licensed Occupations Face Antitrust Scrutiny?*, 162 U. PA. L. REV. 1093, 1096–97 (2014); Alexander Volokh, *The New Private Regulation Skepticism: Due Process, Non Delegation, and Antitrust Challenges*, 37 HARV. J.L. & PUB. POL'Y 931, 933 (2014).

suaded that [restrictive] licensure has reduced both the quantity and quality of medical practice; . . . that it has forced the public to pay more for less satisfactory medical service, and that it has retarded technological development both in medicine itself and in the organization of medical practice."[23]

In addition to constraining telehealth, norms of physician primacy limit other licensed health professions with extensive training in diagnosis and treatment. For example, the scientific case for expanding nursing practice is well established, but Texas and a few other states still deny advanced practice nurses with demonstrably adequate training the ability to practice independently.[24] Barriers to market entry of this type are immune from federal antitrust scrutiny when they are imposed directly by politically accountable state legislatures, but highlight the loss of competition and innovation associated with deference to physicians.[25]

Since Milton Friedman's time, medical boards have made, or been forced to make, limited changes that improve their utility to consumers and the public. These reforms have emphasized the addition of a few lay or non-physician members, as well as greater transparency to the public about licensees. Properly

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[23] MILTON FRIEDMAN, CAPITALISM AND FREEDOM 149–59 (1962).

[24] INSTITUTE OF MEDICINE, THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH (Oct. 5, 2011); National Council of State Boards of Nursing, Implementation Status Map, https://www. ncsbn.org/5397.htm (visited Aug. 31, 2016).

[25] Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143 (2014).

applied, the Supreme Court's ruling in *North Carolina Dental* even more effectively protects market entry and innovation in health care from anti-competitive medical board decision-making.

IV. Using Active Supervision To Restore The People's Policy Voice

When an action taken by a professional licensing board comprised of a majority of the licensed profession is challenged as anticompetitive, the Supreme Court has instructed lower courts to require active supervision by the state itself before conferring on the board immunity from federal antitrust laws. *North Carolina Dental*, 135 S. Ct. at 1101. The purpose of supervision is to ensure that the board's action reflects a sovereign state's policy decision to reduce or displace competition, for which the state is politically accountable.

Accreted physician self-regulation, particularly at the state level, stands as an obstacle to achieving competitive efficiencies through market entry and innovation. The pervasiveness of such embedded, self-protective practices also helps explain why the health care system is so *persistently* inefficient, notwithstanding a clear understanding of the problem and explicit regulatory efforts to decrease waste, promote value-based care, and increase affordable access. Markets distorted by unsupervised, collective restraints on trade are neither self-correcting nor straightforward to alter by enacting additional laws. Moreover, private market power that already may exist in concentrated physician, hospital, or health insur-

ance markets, and that may not be addressable through direct antitrust enforcement, is made much worse by barriers to competitive entry that are not truly state policy.

As contemplated by *North Carolina Dental*, it therefore is important for states to systematically evaluate and then supervise self-regulatory structures and processes that can impede both competition and innovation. Medical licensing does not constitute a comprehensive regulatory regime so much as a path-dependent agglomeration of authorities and conventions. Some of this self-regulatory infrastructure will, on review by government, comport with current state policy and possess procedural safeguards to ensure that it is not misused. But some will not pass muster either as the state's choice or as procompetitive private activity, and should be amended or eliminated if *North Carolina Dental* is correctly applied.

A. Active Supervision Goes Beyond "Per Se" Violations

Rules formulated by state medical boards convey ethics and expertise but also import biases and suffer from blind spots, which are well illustrated in the current litigation. Primary among these is literally the patient "not seen": someone with medical need but lacking the resources or proximity to access physicians in conventional encounters. In this case, the Board has been insufficiently attentive to the potential benefits of affordable, technology-enabled, readily available forms

of physician care. Nor do physician-dominated boards routinely and objectively evaluate the justifications for established professional norms, while often leaping to "protect" patients from practice models developed outside the profession. In this case, the Board was quick to excuse the casual but established practice of "call coverage" from the rules it adopted to hinder Teladoc's model of structured telephonic consultation, *see* 40 Tex. Reg. 2859, 3150-51 (May 29, 2015), even if the distinction makes little logical sense.

This is not to imply that professional licensing boards act in bad faith, but rather to suggest that their private perceptions of the public interest are limited by habit and tunnel vision. As a result, the anticompetitive practices that most need to be subjected to state supervision under *North Carolina Dental* are seldom naked offenses such as price fixing or market division, but rather more subtle forms of discrimination, exclusion, or resistance to market forces that are individually unjustifiable as pro-competitive interventions, and that cumulatively have become major obstacles to achieving consensus health system objectives.

With respect to the application to this case of the holding in *North Carolina Dental*, these background conditions suggest that active supervision of medical licensing board actions should be unaffected by whether or not the defendant committed "per se" violations of antitrust law. Even without state action protection, the rule of reason will do exactly what it exists to do, which is to determine –

on a "quick look" or in a comprehensive balancing – whether the pro-competitive or anti-competitive effects of unsupervised board activity predominate.

B. Social Benefits Do Not Excuse Active Supervision

The existence of social benefits apart from competition does not insulate licensing board actions from active supervision requirements. To the contrary, active supervision is most needed when non-economic and economic effects intertwine. Why should recipients of health care pay a significantly higher price, or sacrifice quality, choice, convenience, or innovation, in exchange for benefits that someone other than the state, acting through accountable democratic processes, has determined sufficiently worthy to outweigh their clear interests as consumers? The Supreme Court has made clear that antitrust law prevents a group of private actors from preempting "the working of the market by deciding for itself that customers do not need that which they demand." *FTC v. Indiana Fed'n of Dentists*, 476 U.S. 447, 462 (1986).

Requiring active supervision of physician-dominated medical boards does not force state agencies to favor federal competition policy over state health policy, but merely enables pro-competitive economic norms to emerge from the shadow of anti-competitive professional habits. Should a state actively supervise its professional boards, the antitrust laws will defer to state policy. Failing that, however, actions by boards controlled by a majority of the self-regulating profession – the

North Carolina Dental standard -- should be directed at improving rather than impairing competition.

Absent clearly articulated state policy accompanied by active supervision, the Supreme Court's footnoted reservation in *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 788 n.17 (1975), therefore should not be read to protect state medical boards from full application of the antitrust laws. In the *California Dental* case, while citing *Goldfarb*, the Supreme Court treated the permissibility of a dental association's restrictions on advertising as an empirical question of how well the market would function with limited information, not as a theoretical debate over whether markets or professional judgment should be controlling. *California Dental Ass'n v. FTC*, 526 U.S. 756, 774-75 (1999). Accordingly, unsupervised self-regulation by a state medical board controlled by physicians should be judged on its pro-competitive or anti-competitive effects.

C. Administrative and Constitutional Oversight of the Board are Insufficient to Ensure Political Accountability

This litigation has forced the appellants to weave a supervisory fabric out of disparate and often unrelated threads that lack the strength the appellants claim. The court's obligation is to ensure the reality of the state's attire, not to flatter an imperial Board by praising clothes that do not in fact exist. Supervision is a matter of substance, not style.

As a matter of health policy, judicial review under state administrative law is not an effective vehicle for active supervision of state medical boards given their substantial discretionary authority. Unlike most administrative agencies, medical boards are expert but not fully accountable decision-makers. Physicians serving on medical boards tend to be regarded as independent authorities on appropriate practice rather than as skilled analysts of objective scientific evidence. As a practical matter, the Board is therefore even less accountable than most agencies because the deference that courts owe to the agency under state administrative law is compounded by the traditional deference given to physicians. Moreover, this hyper-deference gives political cover to supplemental restrictions backed by narrow interest groups that are not in the public interest but seem consistent with established self-regulation, creating exactly the "gauzy cloak of state involvement" criticized by the Supreme Court in *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 106 (1980). Ensuring political accountability for health policy actions therefore requires a form of supervision that differentiates professional from regulatory decision-making.

In *Patel v. Texas Department of Licensing & Regulation*, 469 S.W.3d 69 (2015), the Texas Supreme Court voided licensing requirements placed on eyebrow-threaders by the state's cosmetology board as infringing substantive due process rights under the Texas Constitution. Constitutional review, however, is an

exceptional remedy, not a routine process that comports with the *North Carolina Dental* standard. Moreover, Texas has not demonstrated that its courts can limit the self-regulatory authority of the state's most powerful professions – such as the Board – even if they can say "no" to cosmetologists.

Texas can do better. The health policy goal is not to subject state medical boards to a constant threat of antitrust litigation, but to institute changes that reduce their ability to obstruct competition. This can be achieved in several ways, such as creating a uniform process of substantive review of Board decisions by an umbrella state agency, or restructuring the existing Board to eliminate control by active physicians. For example, a more diversified, inter-professional approach to setting practice standards is being developed by the Tri-Regulator Collaborative, a joint effort of the Federation of State Medical Boards, National Association of Boards of Pharmacy, and National Council of State Boards of Nursing.[26]

V. Conclusion

North Carolina Dental sheds necessary light on a major but hidden problem of inefficiency and lack of consumer responsiveness in health care. Monitoring professional self-regulation that unreasonably restrains trade does not undermine the state's ability to protect public health. To the contrary, assuring active super-

[26] *See, e.g.,* Tri-Regulator Collaborative Position Statement on Interprofessional, Team-based Patient Care (2014), https://www.ncsbn.org/3848.htm (visited Sept. 8, 2016).

vision as directed by the Supreme Court assists health policy, leading to outcomes that are good for states, good for patients, and good for the public.

This case offers the State of Texas an opportunity to embrace legal and political accountability for the actions of its medical board, and thereby to bring its health policy into closer alignment with normal governmental processes and competitive-market defaults. Traditional physician self-regulation is merely an enabling frame for a loose set of old-fashioned assumptions about physicians' economic, moral, and scientific authority that are both logically and empirically unsupported. Antitrust scrutiny will ensure that physician-controlled licensing boards actually advance the public interest, not just their imperfect perceptions of it.

The public interest in a competitive system that empowers patients, keeps care accessible and affordable, and generates ongoing improvements in quality and safety is now greater than ever. Decades of research in health policy confirm that opaque and often unscientific self-regulatory processes controlled by physicians have failed to protect patients or serve the public interest. Affirming the District Court will benefit Texas by holding the Board accountable for injuries to competition and consumers, and should induce the State to develop a functional system of active supervision capable of re-examining (and modifying as desired) the morass

of self-regulatory privilege that currently impedes effective competition in health care and contributes to annual waste of roughly $1 trillion in the United States.

Therefore, the Board's state action defense should be denied.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE WITH RULE 32(a)

1. This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains 5892 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2007 in 14-point Times New Roman font.

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CERTIFICATE OF FILING AND SERVICE

I hereby certify that I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system on September 9, 2016. To the best of my knowledge, all parties to this appeal are represented by counsel who are registered CM/ECF users and service will be accomplished by the appellate CM/ECF system.

Date: September 9, 2016

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