UNITED STATES OF AMERICA
FEDERAL TRADE COMMISSION
WASHINGTON, D.C. 20580

Office of Policy Planning
Bureau of Competition
Bureau of Economics

January 29, 2016

The Hon. Valencia Seay
Georgia State Senate
420 State Capitol
Atlanta, Georgia 30334-2000

Dear Senator Seay:

The staffs of the Federal Trade Commission's Office of Policy Planning, Bureau of Economics, and Bureau of Competition[1] appreciate the opportunity to respond to your invitation for comments[2] on the likely competitive impact of House Bill 684[3] ("HB 684"), which would expand the safety-net settings where Georgia dental hygienists may work without the direct supervision of a dentist. In addition, HB 684 provides that dental hygienists would no longer require direct supervision to screen patients for conditions warranting referral to a dentist, regardless of their location. Removing the direct supervision requirements under these circumstances would likely enhance competition in the provision of preventive dental care services and thereby benefit Georgia consumers, particularly underserved populations with limited access to preventive care.

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.[4] Competition is at the core of America's economy,[5] and vigorous competition among sellers in an open marketplace 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,[6] research,[7] and advocacy.[8]

FTC staff has addressed competition issues related to oral health care,[9] including supervision of dental hygienists in public health settings, 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 the ability of dental hygienists to provide preventive dental services in schools without a prior examination 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 December 2010, FTC staff urged that the Georgia Board of Dentistry not adopt 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.[13] In November 2011, FTC staff urged the Maine Board of Dental Examiners not to adopt proposed rules that would have restricted the scope of practice of Independent Practice Dental Hygienists 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.[14]

Several FTC staff advocacy comments also have addressed supervision requirements for advanced practice registered nurses ("APRNs"). A 2014 FTC staff policy paper, *Policy Perspectives: Competition and the Regulation of Advanced Practice Registered Nurses,* presents an in-depth analysis of the issue and explains that undue supervision requirements may exacerbate health provider shortages, increase health care costs and prices, and constrain innovation in health care delivery models.[15] In the context of analyzing APRN regulations in many states, FTC staff has concluded that removing excessive supervision requirements can promote competition and achieve significant consumer benefits.[16]

II. CURRENT GEORGIA LAW AND PROPOSED AMENDMENTS TO SUPERVISION REQUIREMENTS FOR DENTAL HYGIENISTS

With few exceptions, current Georgia law requires dental hygienists to work under the direct supervision of a licensed dentist,[17] typically the highest supervision level imposed by a state.[18] In Georgia, direct supervision means that a licensed dentist "is in the dental office or treatment facility, personally diagnoses the condition to be treated, personally authorizes the procedures and remains in the dental office or treatment facility while the procedures are being performed by the dental hygienist and, before dismissal of the patient, examines the patient."[19] This direct supervision requirement restricts the conditions and locations in which hygienists may provide services by limiting their practice to facilities where a dentist is physically present.[20] Accordingly, the potential negative effect of a direct supervision requirement is greatest precisely where there is the most need for dental health professionals—underserved communities in dental health professional shortage areas, where dentists are often scarce or unavailable.

Georgia law does not require direct supervision when dental hygienists provide care "at approved dental facilities of the Department of Public Health, county boards of health, or the Department of Corrections."[21] At these locations, Georgia's regulations require a dentist to authorize the dental hygienists' services, but the dentist need not be physically present.[22] Georgia law also allows dental hygienists to provide "dental screenings" without direct supervision in a number of public settings, including "schools, hospitals, and clinics and state, county, local, and federal public health programs." A screening is a visual assessment of the oral cavity to determine whether a dentist should provide a more thorough examination.[23]

HB 684 would amend Georgia law to permit dental hygienists to provide care without direct supervision in additional settings: "at approved safety-net settings, including nonprofit

clinics, health care facilities, long-term care facilities, and school based programs; or at other facilities or settings approved by the board."[24] In addition, HB 684 would allow dental hygienists to provide dental screenings in any setting without direct supervision.[25]

III. LIKELY COMPETITIVE IMPACT OF HB 684

Laws and regulations that require hygienists to work under the direct supervision of dentists to provide preventive services are a significant barrier to the use of dental hygienists outside of dentists' offices and in dental shortage areas.[26] A 2001 law review article describes the effects of the direct supervision requirement when hygienists sought to provide dental screenings at schools and health fairs before Georgia amended its supervision laws in 2001 to remove the requirement of direct supervision of such screenings in public health settings. The article found that when dentists were available, the direct supervision requirement sometimes resulted in an inefficient duplication of efforts by dentists and dental hygienists. When dentists were not available, however, the requirement had an even more dramatic effect, resulting in the complete exclusion of dental hygienists who sought to provide screenings.[27]

Georgia continues to rely primarily on direct supervision of most functions provided by dental hygienists. Indeed, it is one of only a handful of states that did not relax its supervision requirements for dental hygienists between 1993 and 2011.[28] Most states require only general supervision, which requires a dentist to authorize care by hygienists, but does not require the dentist to be physically present.[29] Thirty-eight states have gone even further, allowing direct access to dental hygienists without a dentist's authorization under certain circumstances.[30]

HB 684 takes a step toward reducing the barrier to preventive oral care created by direct supervision requirements.[31] Its proposed expansion of settings where dental hygienists may provide care without the direct supervision of a dentist is consistent with trends in a majority of states, which typically have lower supervision levels in public health and non-dental office settings such as schools, prisons, and nursing homes; some also reduce supervision for the care of homebound individuals in private homes.[32] By increasing the availability of dental hygienists' services outside of dentists' offices, these initiatives can increase the number of suppliers of preventive dental care. The initiatives thereby promote greater competition in the provision of oral health services. Greater competition may, in turn, enhance access to affordable preventive services, mitigate the broader health consequences of dentist shortages, and facilitate the development of innovative models for delivering care.[33] Indeed, dental hygienists are well-positioned to alleviate limited access to preventive dental care arising from dentist shortages because they outnumber dentists by approximately 20%.[34]

The enhanced supply of providers likely to result from reduced supervision requirements could be especially effective in improving access to dental services in Georgia's underserved areas, where dentists may not be available.[35] In the United States, the oral health workforce is not well distributed, and access to dentists and dental care is inadequate in many areas. This is the case in some parts of Georgia, where 148 locations have been designated as Dental Care Health Professional Shortage Areas ("DCHPSA"). In Georgia, 14.5% of the population lives in a DCHPSA, and the percent of need met by dentists is only 27%.[36] Elimination of the direct supervision requirement will help alleviate some of these dental care shortages, and facilitate

greater competition, which could reduce costs and prices. Even though dental hygienists earn considerably less than dentists,[37] their ability to provide cost-effective care is tied to their ability to offer safe and effective services without a dentist on site. Direct supervision requiring the physical presence of a dentist undercuts the cost savings that would otherwise arise from the use of a dental hygienist because it requires payment for the dentist's services, as well as costs related to transporting the dentist to non-dental facilities.[38] Moreover, the increased availability of dental hygienists at local safety-net settings that would arise if the direct supervision requirement were eliminated would also be likely to reduce patients' transportation costs.[39] Thus, elimination of the direct supervision requirement and the likely increase in competition and access arising from HB 684 could reduce the costs of treatment for patients and lead to savings for government benefit programs.[40]

By contrast, retention of the direct supervision requirement would likely limit competition and decrease access to dental hygienists without providing any countervailing benefits to health care consumers. 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' concerns about quality and safety, which boards sometimes raise to justify restrictions on hygienists' practicing without supervision in settings where dentists are not available.[41] 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.[42] The IOM 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[.]"[43] HB 684 appears to be a step in this direction. By eliminating the requirement of direct supervision for dental screenings in any setting, and for preventive dental care in expanded safety-net settings, HB 684 will likely increase dental hygienists' ability to provide services within the scope of their education and training, such as prophylaxis and the application of fluoride and dental sealants. By doing so, HB 684 has the potential not only to improve oral health, but also to contribute more generally to Georgians' physical health and well-being.[44]

IV. CONCLUSION

By eliminating the direct supervision requirement for dental hygienists' services delivered in expanded safety-net settings, and for dental screenings delivered in any setting, HB 684 will likely promote greater competition in the provision of preventive dental care services, leading to increased access and more cost-effective care, especially for Georgia's most vulnerable populations. Retaining the direct supervision requirement in the settings covered by HB 684 would likely preclude these benefits of competition. Finally, authoritative sources have found no countervailing health or safety benefits to health care consumers from such requirements. Accordingly, HB 684 appears to be a procompetitive improvement in the law that would benefit Georgia health care consumers.

Respectfully submitted,

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[1] This letter expresses the views of 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 voted to authorize us to submit these comments.

[2] Letter from Valencia Seay, Senator, Georgia Senate, to Karen Goldman, Attorney Advisor, Office of Policy Planning, Fed. Trade Comm'n (June 23, 2015) (on file with Office of Policy Planning).

[3] HB 684 (LC 33 6136, 2015-2016) (to amend GA. CODE ANN. § 43-11-74), http://www.legis.ga.gov/Legislation/20152016/152664.pdf.

[4] Federal Trade Commission Act, 15 U.S.C. § 45.

[5] 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.").

[6] *See generally* FTC STAFF, OVERVIEW OF FTC ANTITRUST ACTIONS IN HEALTH CARE SERVICES AND PRODUCTS (2013), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/hcupdaterev.pdf.

[7] *See, e.g.*, FTC & U.S. DEP'T OF JUSTICE ("DOJ"), IMPROVING HEALTH CARE: A DOSE OF COMPETITION (2004), http://www.ftc.gov/reports/healthcare/040723healthcarerpt.pdf.

[8] FTC and staff advocacies take many forms, including letters or comments addressing specific policy issues, Commission or staff testimony before legislative or regulatory bodies, and amicus briefs. *See, e.g.*, FTC Staff Letter to the Hon. Rep. Stephen LaRoque, North Carolina House of Representatives, Concerning North Carolina House Bill 698 and the Regulation of Dental Service Organizations and the Business Organization of Dental Practices in North Carolina (May 25, 2012), http://ftc.gov/os/2012/05/1205ncdental.pdf; FTC and DOJ Written Testimony before the Illinois Task Force on Health Planning Reform Concerning Illinois Certificate of Need Laws (Sept. 15, 2008), https://www.ftc.gov/sites/default/files/documents/advocacy_documents/ftc-and-department-justice-written-testimony-illinois-task-force-health-planning-reform-concerning/v080018illconlaws.pdf; Brief of the FTC as Amicus Curiae in Actelion Pharmaceuticals Ltd. v. Apotex Inc., No. 1:12-cv-05743-NLH-AMD (D. N.J.) (Mar. 11, 2013), http://www.ftc.gov/os/2013/03/130311actelionamicusbrief.pdf .

[9] *See, e.g.*, Comment from FTC Staff to the Texas State Bd. of Dental Exam'rs (Oct. 6, 2014) (concerning proposed restrictions on the ability of Texas dentists to enter into agreements with non-dentists for administrative services), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2014/10/ftc-staff-comment-texas-state-board-dental-

examiner-0; Comment from FTC Staff to the Comm'n on Dental Accreditation (Dec. 2, 2013) (concerning accreditation standards for dental therapists), http://www.ftc.gov/policy/policy-actions/advocacy-filings/2013/12/ftc-staff-comment-commission-dental-accreditation; 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) (concerning proposed rules on the practice of portable and mobile dentistry), http://www.ftc.gov/os/2009/12/091224commentladentistry.pdf); Comment from FTC Staff to the La. House of Representatives (May 1, 2009), http://www.ftc.gov/os/2009/05/V090009louisianadentistry.pdf; Comment from FTC Staff to the La. House of Representatives (May 22, 2009) (concerning legislation on the practice of in-school dentistry), http://www.ftc.gov/os/2009/05/V090009louisianahb687amendment.pdf; *see generally Advocacy Filings by Subject, Dentistry*, FED. TRADE COMM'N, http://ftc.gov/opp/advocacy_subject.shtm#detg (last visited Jan. 21, 2016).

[10] *See* S.C. State Bd. of Dentistry, 138 F.T.C. 229, 233-40 (2004), http://www.ftc.gov/os/decisions/docs/Volume138.pdf#page=234.

[11] *See id.* at 232, 268-80.

[12] S.C. State Bd. of Dentistry, Dkt. No. 9311 (F.T.C. 2007) (decision and order), https://www.ftc.gov/sites/default/files/documents/cases/2007/09/070911decision_0.pdf. 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] FTC Staff Comment Before the Georgia Board of Dentistry Concerning Proposed Amendments to Board Rule 150.5-0.3 Governing Supervision of Dental Hygienists (Dec. 30, 2010), http://ftc.gov/os/2010/12/101230gaboarddentistryletter.pdf. The Board did not adopt the proposed rule requiring indirect supervision. In 2012, it adopted a revised rule that requires a supervising dentist to authorize the provision of services, either in person, through video conferencing, by written standing orders, or through department protocols. *See infra* note 22; Secretary of State/Professional Licensing Boards Division/Board of Dentistry, Notice of intent to adopt amendments to the Georgia Board of Dentistry Board Rules 150-5-.03 Supervision of Dental Hygienists and Notice of Public Hearing, 2012 GA Regulation Text 5775, Feb. 20, 2012.

[14] FTC Staff Comment Before the Maine Board of Dental Examiners Concerning Proposed Rules to Allow Independent Practice Dental Hygienists to Take X-Rays in Underserved Areas (Nov. 16, 2011), http://ftc.gov/os/2011/11/111125mainedental.pdf. The Board subsequently voted to allow IPDHs to take only those certain x-rays.

[15] *See* FED. TRADE COMM'N STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES III.A., 38 (2014) (mandatory supervision and agreement requirements are likely to lead to "decreased access to health care services, higher health care costs, reduced quality of care, and less innovation in health care delivery."), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

[16] *See* Comment from FTC Staff to the South Carolina House of Representatives 2 (Nov. 2, 2015), https://www.ftc.gov/policy/policy-actions/advocacy-filings/2015/11/ftc-staff-comment-south-carolina-representative-jenny.

[17] *See* GA. CODE ANN. § 43-11-74(a) ("Dental hygienists shall perform their duties only under the direct supervision of a licensed dentist. . . .").

[18] *See, e.g.*, April V. Catlett & Robert Greenlee, *A Retrospective Comparison of Dental Hygiene Supervision Changes from 2001 to 2011*, 87 J. DENTAL HYGIENE 110, 112 (2013); American Dental Hygienists' Ass'n, *Dental Hygiene Practice Act Overview: Permitted Functions and Supervision Levels by State* (Sept. 2015) (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"), https://www.adha.org/resources-

docs/7511_Permitted_Services_Supervision_Levels_by_State.pdf. There are no express provisions for indirect supervision, general supervision, or direct access in Georgia laws or regulations, but the regulatory requirement of a dentist's authorization for dental hygienists services provided at certain public facilities is comparable to a requirement of general supervision. *See infra* note 22 and accompanying text.

[19] GA. COMP. R. & REGS. 150-5-.03 (Supervision of Dental Hygienists).

[20] Catlett & Greenlee, *supra* note 18, at 110.

[21] GA. CODE ANN. § 43-11-74(d).

[22] Currently, Georgia regulations require a dentist to authorize the services provided by dental hygienists in these 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).

[23] GA. CODE ANN. § 43-11-74(e)(1), (2).

[24] HB 684, GA. CODE ANN. § 43-11-74(d) (proposed). HB 684 would also strike the language at GA. CODE ANN. § 43-11-74(d) requiring the Georgia Board of Dentistry to provide regulations specifying a level of supervision at public health and safety-net settings, suggesting that authorization by a dentist might not be required. However, HB 684 does not propose to amend current Georgia law that generally authorizes the Georgia Board of Dentistry to adopt regulations on the scope of practice and supervision of dental hygienists. *See* GA. CODE ANN. § 43-11-9. Thus, it is not clear whether HB 684 alters the authority of the Georgia Board of Dentistry to adopt or retain regulations requiring a dentist to authorize services provided by dental hygienists.

[25] *See* HB 684, GA. CODE ANN. § 43-11-74(e)(2) (proposed).

[26] *See* NATIONAL GOVERNORS ASS'N, THE ROLE OF DENTAL HYGIENISTS IN PROVIDING ACCESS TO ORAL HEALTH CARE 4-5 (2014); Catlett & Greenlee, *supra* note 18, at 110 ("direct supervision confines the dental hygienist to a facility where the dentist is physically present"); *Dental Hygienists: Demand for Dental Hygienists, in* INSTITUTE OF MEDICINE, 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.").

[27] *See* Amy Pressley McCarthy, *Dentists and Dental Hygienists: Allow Dental Hygienists to Perform Dental Screenings without Supervision Under Certain Conditions; Provide for Information and Fees*, 18 GA. ST. U.L. REV. 238, 239 (2001) (effects of the direct supervision requirement based on the author's telephone interview of Martha S. Phillips, Executive Director of the Georgia Dental Association). In 2001, Georgia dentists apparently recognized that requiring direct supervision of screenings created a barrier to care in public health settings and determined that such supervision was unnecessary for the health and safety of screenings in those settings. As a result, both dentists and hygienists supported the 2001 bill drafted by the Georgia Dental Association, which ultimately eliminated the requirement that dentists directly supervise hygienists' screenings in schools, hospitals, clinics, and a number of public health programs. *See id.* at 239-40.

[28] *See* Catlett & Greenlee, *supra* note 18, at 114-115 (45 out of 51 jurisdictions reduced dental hygienists' supervision requirements from 2001-2011, but Alabama, Georgia, Mississippi, and North Carolina rely on direct supervision and have made little progress in reducing supervision); *see also* American Dental Hygienists' Ass'n, *Dental Hygiene Practice Act Overview: Permitted Functions and Supervision Levels by State* (Sept. 2015), https://www.adha.org/resources-docs/7511_Permitted_Services_Supervision_Levels_by_State.pdf . By adopting a regulation in 2012 that requires a dentist's authorization for dental hygiene services provided at the Dept. of Public Health, county boards of health, and the Dept. of Corrections, Georgia effectively *increased* the level of supervision during the last 10 years. *See supra* notes 13, 22.

[29] *See* American Dental Hygienists' Ass'n, *Dental Hygiene Practice Act Overview: Permitted Functions and Supervision Levels by State* (Sept. 2015), https://www.adha.org/resources-docs/7511_Permitted_Services_Supervision_Levels_by_State.pdf ; *see also* Georgia Dental Hygienists' Ass'n, *It's Time for Georgia to "Catch Up" on Oral Health Care Provisions* (2015) (45 states allow dental hygienists to work under general supervision, which does not require a dentist to be present in the treatment facility).

[30] *See* American Dental Hygienists' Ass'n, *Current Direct Access Map 2016: 38 States* (Jan. 2016), http://www.adha.org/direct-access. 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 dentists, treat the patient without the presence of a dentist, and maintain a provider-patient relationship . . . ." American Dental Hygienists' Ass'n, *Direct Access States* 1 (Sept. 2015), http://www.adha.org/direct-access. *See also* D.K. Naughton, *Expanding oral care opportunities: direct access care provided by dental hygienists in the United States*, 14 J. EVID. BASED DENT. PRACT. SUPPL. 171 (2014).

[31] Consistent with the trends in other states, Georgia may wish to consider eliminating direct supervision altogether, so that all consumers could benefit from increased access and other potential benefits of greater competition (e.g., expanded hours/locations of service, possible price competition, etc.).

[32] *See* Catlett & Greenlee, *supra* note 18, at 114-116; NATIONAL GOVERNORS ASS'N , *supra* note 26, 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.").

[33] *See* Catlett & Greenlee, *supra* note 18, at 110, 111, 116; NATIONAL GOVERNORS ASS'N, *supra* note 26, at 4.

[34] *See* NATIONAL GOVERNORS ASS'N, *supra* note 26, at 4.

[35] Some studies suggest that reduced supervision requirements for dental hygienists contribute to improved access to dental health care for underserved populations in a number of states. *See* Catlett & Greenlee, *supra* note 18, at 111, 116. *See also A Vision for the Delivery of Oral Health Care to Vulnerable and Underserved Populations*, *in* COMMITTEE ON ORAL HEALTH ACCESS TO SERVICES, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 234 (2011) (As a result of overly restrictive scope of practice and supervision regulations, "states may miss critical opportunities to serve greater numbers of individuals in need of care.").

[36] The Henry J. Kaiser Family Foundation, Dental Care Health Professional Shortage Areas (April 28, 2014), 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 2 (June 2012), http://kaiserfamilyfoundation.files.wordpress.com/2013/01/8324.pdf (based on 2010 census data at http://www.census.gov/2010census/data/).

[37] *See* COMMITTEE ON ORAL HEALTH ACCESS TO SERVICES, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 87 (2011) (mean annual wage of $143,000 for salaried general dentists, compared to $66,500 for dental hygienists).

[38] For a discussion of how requirements to have a dentist on-site could undercut the savings arising from the use of dental therapists, mid-level dental providers who earn less than dentists, *see* Comment from FTC Staff to the Comm'n on Dental Accreditation 5 (Dec. 2, 2013), http://www.ftc.gov/policy/policy-actions/advocacy-filings/2013/12/ftc-staff-comment-commission-dental-accreditation. 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* FED. TRADE COMM'N STAFF, POLICY PERSPECTIVES: COMPETITION AND THE REGULATION OF ADVANCED PRACTICE NURSES 27-28 (2014), https://www.ftc.gov/system/files/documents/reports/policy-perspectives-competition-regulation-advanced-practice-nurses/140307aprnpolicypaper.pdf.

[39] *See, e.g.*, Brian E. Whitacre, *Estimating the Economic Impact of Telemedicine in a Rural Community*, 40 AG. RES. ECON. REV. 172, 176-178 (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; Georgia Department of Community Health, Medicaid FAQs (Georgia Medicaid program pays for "non emergency medical transportation services").

[40] For example, the Georgia Department of Public Health states that "[p]ublic health dental services are provided to children who are enrolled in Medicaid and PeachCare programs, as well as to low-income patients on a sliding-fee

scale (based on the patient's ability to pay." Georgia Dep't of Public Health, Oral Health, https://dph.georgia.gov/oral-health.

[41] *See* NATIONAL GOVERNORS ASS'N, *supra* note 26, 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 18, 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").

[42] *A Vision for the Delivery of Oral Health Care to Vulnerable and Underserved Populations, in* COMMITTEE ON ORAL HEALTH ACCESS TO SERVICES, INSTITUTE OF MEDICINE AND NATIONAL RESEARCH COUNCIL, IMPROVING ACCESS TO ORAL HEALTH CARE FOR VULNERABLE AND UNDERSERVED POPULATIONS 234 (2011).

[43] *Id.* at 235.

[44] *See* NATIONAL GOVERNORS ASS'N, *supra* note 26, at 1, 4; INST. OF MED., NAT'L ACADS., ADVANCING ORAL HEALTH IN AMERICA 16-17, ch. 2 (2011) (discussing the connection between oral health and overall health and well being), http://www.nap.edu/catalog.php?record_id=13086&utm_expid=4418042-5.krRTDpXJQISoXLpdo-1Ynw.0&utm_referrer=http%3A%2F%2Fwww.iom.edu%2FReports%2F2011%2FAdvancing-Oral-Health-in-America.aspx.