No. 13-534

IN THE

Supreme Court of the United States

THE NORTH CAROLINA STATE BOARD
OF DENTAL EXAMINERS,

Petitioner,

v.

FEDERAL TRADE COMMISSION,

Respondent.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

BRIEF OF THE AMERICAN ASSOCIATION OF NURSE ANESTHETISTS, AMERICAN NURSES ASSOCIATION, AMERICAN ASSOCIATION OF NURSE PRACTITIONERS, AMERICAN COLLEGE OF NURSE MIDWIVES, NATIONAL ASSOCIATION OF CLINICAL NURSE SPECIALISTS, AND THE CITIZEN ADVOCACY CENTER AS *AMICI CURIAE* IN SUPPORT OF THE RESPONDENT

KATHRYN K. CONDE
Counsel of Record
HILARY S. BLACKWOOD
NUTTER MCCLENNEN & FISH LLP
155 Seaport Boulevard
Boston, MA 02210
(617) 439-2000
kconde@nutter.com

Counsel for Amici Curiae

254380

COUNSEL PRESS
(800) 274-3321 • (800) 359-6859

TABLE OF CONTENTS

TABLE OF CONTENTS

TABLE OF CITED AUTHORITIES

Page

Cases

TABLE OF CITED AUTHORITIES

Statutes and Other Authorities

TABLE OF CITED AUTHORITIES

Page

Cited Authorities

Page

INTEREST OF *AMICI CURIAE*[1]

Amici curiae are national associations of nursing professionals, including associations of advanced practice registered nurses with areas of practice in anesthesia, primary care, acute care, mental health, labor and delivery and other specialties. Advanced practice registered nurses ("APRNs") have extended their formal academic and clinical education with masters or doctoral degrees in their area of expertise and evaluate, diagnose and treat patients and prescribe medications as part of their advanced nursing practice.

These nursing associations are dedicated to fostering the professionalism and quality of the nursing profession, generally, and of their respective area of nursing practice and facilitating access to nursing care by promoting the ability of member nurses to safely practice to the full extent of their professional training and education. Members of *amici* nursing associations are both regulated by and often serve on boards of nursing in the 50 states and the District of Columbia.

- American Association of Nurse Anesthetists, founded in 1931, is the professional association representing nearly 47,000 Certified Registered Nurse

[1] Petitioner and Respondent filed with the Clerk of the Supreme Court letters granting blanket consent to the filing of *amicus* briefs. *Amici* certify pursuant to Rule 37.6 that no counsel for any party authored this brief in whole or in part, and no person or entity other than *amici* organizations or their counsel has made any monetary contribution intended to fund preparation or submission of this brief.

Anesthetists ("CRNAs") and student registered nurse anesthetists nationwide. CRNAs administer anesthesia and provide pain management care.

- The American Nurses Association (ANA) is the only full-service professional organization representing the interests of the nation's 3.1 million registered nurses through its constituent and state nurses associations and its organizational affiliates. ANA advances the nursing profession in furtherance of its mission to improve health for all by fostering high standards of nursing practice, promoting the rights of nurses in the workplace, projecting a positive and realistic view of nursing, and lobbying the Congress and regulatory agencies on health care issues affecting nurses and the public.

- American Association of Nurse Practitioners is the largest professional membership organization for nurse practitioners ("NPs") of all specialties, representing NP students and more than 192,000 NPs practicing in the United States today.

- American College of Nurse Midwives ("ACNM") is the national professional association representing 11,000 certified nurse-midwives and certified midwives licensed in all 50 states and the District of Columbia to provide both maternity and

primary care services. With roots dating to 1929 and formal incorporation in 1955, ACNM is the oldest women's health care organization in the U.S.

- National Association of Clinical Nurse Specialists, founded in 1995, is the only association representing clinical nurse specialists ("CNSs"), advanced practice registered nurses who work in a variety of specialties to ensure high-quality, evidence-based, patient-centered care. As leaders in health care settings, CNSs provide direct patient care and lead initiatives to improve care and clinical outcomes and to reduce costs.

Amici nursing associations are concerned about actions of state healthcare professional regulatory boards that impact the ability of nursing professionals to practice to the fullest extent of their professional training and education. Unnecessary restrictions on the practice of any qualified healthcare provider limit patient access to quality care, may increase cost and can compromise the quality of healthcare delivery. The need to provide access to quality and cost effective healthcare is imperative to meet the growing healthcare needs of our aging population. Ensuring that healthcare professionals are working to the full extent intended by the states and without impermissible anticompetitive interference is vital to addressing those public health challenges.

Amici nursing associations are joined in this brief by the Citizen Advocacy Center ("CAC"), a non-profit,

non-partisan organization whose mission is to increase the accountability, transparency and effectiveness of state healthcare professional regulatory boards and national voluntary certification organizations by offering training, research and networking opportunities for public members serving on these entities. The CAC supports efforts to review unjustifiable anticompetitive business restrictions imposed by state healthcare professional regulatory boards that harm consumers.

SUMMARY OF ARGUMENT

This Court's jurisprudence requires that private parties vested by the state with regulatory authority to limit competition must act both in keeping with a "clearly articulated and affirmatively expressed" state policy to displace competition and be subject to "active state supervision" in order to be insulated from antitrust review by state action immunity. *California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980). The Fourth Circuit decision correctly applied this Court's precedent to find that the North Carolina Board of Dental Examiners (the "Dental Board"), composed of a majority of practicing dentists elected exclusively by other practicing dentists, was not entitled to state action immunity in light of the failure of the state to actively supervise the Dental Board. *N.C. State Bd. of Dental Exam'rs v. FTC*, 717 F.3d 359, 375 (4th Cir. 2013).

When a sovereign state chooses to delegate regulatory authority to private economic actors, the doctrine of state action immunity requires a closer examination of the true nature of the state sanctioned entity and active review by the state of its activities.

FTC v. Phoebe Putney Health Sys., Inc., 133 S. Ct. 1003, 1010 (2013) ("Accordingly, '[c]loser analysis is required when the activity at issue is not directly that of' the State itself, but rather 'is carried out by others pursuant to state authorization.'" (quoting *Hoover v. Ronwin*, 466 U.S. 558, 568 (1984))). A state may not authorize private parties to effect anticompetitive results under the guise of a state regulatory regime without providing active supervision of those activities. *See Midcal*, 445 U.S. at 105, 106. Reversing the Fourth Circuit decision and affording the Dental Board immunity would permit states to cede regulatory authority to private economic actors, armed with the immunity reserved for government actors, without any state review of their activities or even of the selection of those parties, thus permitting professionals in private practice, not elected by or accountable to the general public, to direct the regulatory policy of the state consistent with the economic interests of their profession, rather than the overall public welfare.

Petitioner contends that the designation of the Dental Board under North Carolina statute as a "state agency," cannot be disrupted and is dispositive of whether the Dental Board is a "state actor" for purposes of state action immunity. Under this view of the case, every state regulatory board denominated a "state agency," regardless of its composition, organization or powers, would be entitled to immunity provided it was acting pursuant to a clearly articulated state policy to displace competition. *Phoebe Putney*, 133 S. Ct. at 1010. Such a holding would enfeeble federal antitrust principles by insulating the activities of all state regulatory boards, regardless of their composition, which

are, by definition, acting under a state regime to displace competition.

Precedent does not permit such a broad exception to federal antitrust policy. This Court firmly rejects formalistic approaches to determining whether an actor is a "state actor," and does not permit labels issued by the state or private parties to control its determinations. *See Am. Needle, Inc. v. Nat'l Football League*, 560 U.S. 183, 190-93 (2010) (courts consider "the identity of the persons who act, rather than the label of their hats"); *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 39 (1985) (explaining that "state action is not a purely formalistic inquiry"); *Goldfarb v. Virginia State Bar*, 421 U.S. 773, 789-90 (1975). Nor is there any serious federalism issue in a critical examination of a state's labeling of a privately staffed body as a "state agency." In *Goldfarb*, the Virginia State Bar was denied state action immunity despite the Court's recognition that it was "a state agency by law." *Goldfarb*, 421 U.S. at 789-90. The fact that a state-created body may be "a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members." *Id.* at 791.

Even where the challenged actions of the Arizona State Bar Association were authorized by the Arizona Supreme Court and were undisputedly "acts as the agent of the [state] [Supreme] court," this Court required and relied on the fact that the rules at issue were "subject to the pointed re-examination by the policymaker the Arizona Supreme Court." *Bates v. State Bar of Ariz.*, 433 U.S. 350, 361-62 (1977). In affording state action immunity to the Arizona State Bar enforcing disciplinary rules concerning advertising, this Court "deem[ed] it

significant that the state policy is so clearly and affirmatively expressed and that the State's supervision is so active." *Id.* at 362; *see Midcal*, 445 U.S. at 104-05 (referencing relevance of the "pointed re-examination" by the Arizona State Supreme Court in *Bates* in support of imposing the "active state supervision" test for private activities). As found below, and not contested on appeal, no such "pointed re-examination," or any examination, was made by the state of the Dental Board's activities in this case. *N.C. Bd. of Dental Exam'rs*, 717 F.3d at 370.

The Fourth Circuit decision appropriately reflects the longstanding principle that state action immunity is disfavored, in view of the clear mandate of the federal antitrust laws to preserve competition. *See Phoebe Putney*, 133 S. Ct. at 1010 ("[G]iven the fundamental national values of free enterprise and economic competition that are embodied in the federal antitrust laws, 'state-action immunity is disfavored, much as are repeals by implication.'" (quoting *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621, 636 (1992))). Undue concern for federalism or for the impact on board decision making need not outweigh the imperative of protecting competition, despite suggestions by *amici* in support of Petitioner who contend that affirming the decision will distort board decision making and impose impossible challenges on the states. States can and should continue to engage professionals on their regulatory boards while providing oversight to determine that the boards are correctly effecting the broad economic and regulatory policies of the state legislatures.

This Court should affirm the Fourth Circuit decision for the following four reasons:

First, the Fourth Circuit correctly identified the Dental Board, consisting of a majority of privately elected practicing dentists, as a private actor, under this Court's precedent requiring an examination of the nature of any state-created regulatory entity and of the economic interests of those controlling the entity. *See, e.g.*, *FTC v. Ticor Title Ins. Co.*, 504 U.S. 621 (1992) (analyzing state authorized rating bureaus operated by title insurance companies as private actors under *Midcal* test); *S. Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985) (reviewing state authorized rate bureaus composed of motor common carriers as private actors under *Midcal* test). Unsupervised state regulatory boards constituted with a majority of practicing professionals and interpreting broadly-worded statutes have a tendency to act in their own economic self-interest to protect their competitive position in a manner not intended to be authorized by the state. Practicing healthcare professionals are no less "private actors" than the lawyers at issue in *Goldfarb* or the wine wholesalers in *Midcal*. This Court has refused to adopt an exemption for the "learned professions" or to otherwise presume that professionals act in the public's interest or that they lack the profit motive of non-professional market participants. *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 696 (1978) (rejecting special standards for rule of reason in evaluating ethical cannons of learned profession claimed to protect public safety); *Goldfarb*, 421 U.S. at 786-88 (rejecting learned professions exemption and acknowledging that professions act in "trade or commerce").

Second, the Fourth Circuit correctly declined to treat the Dental Board as akin to a municipality, which

this Court determined in *Hallie* need not be actively supervised by the state when it is acting pursuant to a "clearly articulated state policy to replace competition." *Hallie*, 471 U.S. at 47. The Court's holding in *Hallie*, dispensing with proof of "active state supervision" for the activities of municipalities, has no application to a regulatory board that is elected and controlled by a majority of private market participants. These regulatory boards do not possess the characteristics of local government that provide additional assurance that the board, like a municipality, will act in the public interest, as opposed to the private economic interest of their trade or profession. *See id.* at 45 n.9, 46-47.

Third, concerns stated by *amici* supporting Petitioner that "active state supervision" will compromise the integrity or soundness of board decisions, threaten public safety or otherwise be impractical are unfounded. In the healthcare area, state departments of health or similar state agencies possess ample expertise to evaluate the decisions of healthcare professional regulatory boards. States already recognize the value of involving non-professionals in the decisions of these boards, often requiring consumer and public representatives without healthcare experience to sit on boards of medicine and boards of nursing. While *amici* nursing associations and the CAC recognize the vital role that practicing professionals play on regulatory boards, they disagree with *amici* supporting reversal that "active state supervision" is impracticable. Several states already provide for oversight of boards of nursing by a state agency. *See* discussion *infra* Part IV. State supervision of regulatory boards offers the advantage of fostering communication between practitioner staffed

boards and the state to ensure that the board acts in the best interest of the public.

Amici's arguments that state oversight will be an interference with the activities of professional regulatory boards miss the point. *Amici* nursing associations and the CAC concede the value of optimal policymaking, but the inquiry, for purposes of state action immunity, is not whether the state regulation satisfies a normative standard of quality. The limited purpose of "active state supervision" is to corroborate that the action of an entity operated by private parties is the action of the state. *Ticor Title*, 504 U.S. at 634-35. It turns federalism principles on their head to contend that the state could "interfere" with its own policy. The very federalism concerns that *amici* supporting reversal raise dictate the necessity of assuring that the activities of privately controlled regulatory boards are consistent with the will of the sovereign state.

Fourth, claims that competitors or consumers are adequately protected from the activities of boards controlled by market participants by virtue of government ethics laws and state administrative procedures acts are illusory. These statutes are not directed toward the protection of competition and do not provide assurance that board activity is consistent with the state's policy to displace competition. Federal competition policy should not be surrendered to the vagaries of the state standards which provide no meaningful protection against unwarranted anticompetitive activities of regulatory boards.

ARGUMENT

I. ABSENT "ACTIVE STATE SUPERVISION," MAJORITY STAFFED PROFESSIONAL BOARDS MAY ACT ANTICOMPETITIVELY IN A MANNER NOT CONTEMPLATED BY THE STATE.

A. Regulatory Boards Possess Extensive Powers to Interpret Broad Statutes Affecting the Scope of Practice of Multiple Healthcare Professionals Who Share Increasingly Overlapping Expertise and Scopes of Practice.

In the healthcare area, state professional boards are vested with extensive powers to affect the right of healthcare professionals to practice and to define the scope and conditions of their practice. Generally, these boards are called upon to interpret and enforce statutes governing the scope of practice ("practice acts") and the licensing of one or more classes of healthcare professionals. In most states, boards may effect that responsibility through formal disciplinary actions and rulemaking and through less formal advisory opinions, policy statements and guidelines that they issue. Many states also provide for criminal penalties for the unauthorized practice of healthcare service. *See, e.g.*, Conn. Gen. Stat. § 20-102 (felony or fine); N.C. Gen. Stat. § 90-40 (misdemeanor); 63 Pa. Stat. Ann. § 223(a)-(b) (misdemeanor with option of civil penalties); Utah Code

Ann. § 58-31b-503(1)-(3) (third-degree felony or misdemeanor); W. Va. Code § 30-7-13 (misdemeanor).

In discharging these duties, healthcare professional boards are frequently required to interpret broadly-worded practice acts for the particular professional discipline. *See* Robert Cunningham, *Tapping the Potential of the Health Care Workforce: Scope-of-Practice and Payment Policies for Advanced Practice Nurses and Physician Assistants*, Nat'l Health Pol'y Forum 10 (2010) (referencing "vague" scope of practice statutes "open to a wide range of interpretations").[2] Increasingly, healthcare providers are expanding their educational and professional capabilities to provide additional treatments or services, and new types of providers are being recognized who provide similar services as existing market participants. *See* Catherine Dower & Leonard Finocchio, *Viewpoint on Health Professions Regulation: Strengthening the Links Between the Public Health Community and Health Professional Regulation*, Pub. Health Rep., Sept.-Oct. 1999, at 424 ("Traditional boundaries . . . between the professions have blurred. This evolution has been driven largely by the non-physician professions seeking expanded practice authority and innovation in the workplace. . . ."); Inst. of Med. of the Nat'l Acads., *The Future of Nursing: Leading Change, Advancing Health* 97 (2011) [hereinafter IOM Report] ("[T]he education and role of APRNs have continually evolved so that nurses now enter the workplace willing and qualified to provide more services than they previously did.").

---

[2] *Available at* http://www.nhpf.org/library/background-papers/BP76_SOP_07-06-2010.pdf.

Where professional expertise overlaps, one professional board may render a decision regarding its scope of practice which has the effect of foreclosing other healthcare professionals from providing the service or treatment at issue. Overlapping expertise is particularly prominent between advanced practice registered nurses and physicians and a subject of dispute between these healthcare professionals. *See* Dower & Finocchio, *supra*, at 422 (acknowledging scope of practice disputes between APRNs and physicians); IOM Report, *supra*, at 97 ("As the services supported by evolving education programs expanded, so did the overlap of practice boundaries of APRNs and physicians.").

In interpreting scope of practice statutes, boards of medicine may, for example, declare a treatment or diagnostic test "the practice of medicine," thereby effectively excluding nurses in general, and specifically APRNs, from providing the same service, in cases where the nurses are educated, qualified and otherwise permitted by nursing statute or regulation to offer the service. Alternatively, boards of medicine may require that licensed physicians "supervise" or "direct" nurses where state law does not otherwise require such "supervision" or "direction." Even this more limited restriction severely constrains the ability of consumers to fully and directly access quality healthcare services from nursing professionals and inhibits nurses from practicing their profession to the full extent of their training and education. *See* Dower & Finocchio, *supra*, at 423 (unnecessary limitations on the scope of practice of healthcare professions limits access at a time that "there are thousands of federally and state-designated health manpower shortage areas across the country today"); FTC, *Policy Perspectives: Competition and the*

Regulation of Advanced Practice Nurses 20-33 (2014) (recognizing that excessive supervision requirements imposed on APRNs exacerbate provider shortage areas and may increase costs and hamper innovation);[3] IOM Report, *supra*, at 98-103 (discussing barriers created by on-site physician oversight or supervision requirements).

Where a majority practitioner staffed board is not overseen by an independent state agency or official, board decisions regarding the scope of practice for healthcare professionals are a means of improperly limiting competition beyond the contemplation of the state legislature. This may be particularly true in healthcare, where new treatments, diagnostics, devices and procedures are always being developed and where new healthcare disciplines are recognized or staffing models are being tested in order to address the expanding healthcare needs of our population. *See* IOM Report, *supra*, at 107 ("Practice boundaries are constantly changing with the emergence of new technologies, evolving patient expectations, and workforce issues."). Professional boards are often called upon to determine whether a healthcare practitioner may utilize the new technology or provide the new treatment, under circumstances where the state legislature has never considered the scope of practice question with respect to the particular innovation. Without active state review, professional boards often have no clear guide for applying the practice act to a new development and have a strong incentive to impose an anticompetitive result curtailing patient access to other health care professionals who offer the same care. This

---

[3] *Available at* http://www.nacns.org/docs/FTC140307aprnpolicy.pdf.

decision to limit access to healthcare providers is often one that lawmakers did not consider and would not themselves have authorized.

Aside from formal statutory interpretation of scope of practice and licensing acts, healthcare professional boards may also utilize their powers to investigate or to issue advisory opinions, policy statements and guidelines to effect an anticompetitive result not consistent with the state's legislative intention. These informal, but permissible, board actions can have the same practical effect as an official rulemaking or decision because malpractice insurance carriers, health insurance companies, hospitals and other healthcare facilities frequently follow such informal guidance from boards by incorporating the standards into their credentialing, privileging and conditions of coverage. *See* IOM Report, *supra*, at 102 ("Credentialing and payment policies often are limited to state practice laws."). When a healthcare provider cannot obtain required malpractice insurance or is not permitted to practice at a facility or participate in a provider network, as a result of an unofficial action of the board, the action has the same impact as an official board ruling that restricts or limits competition. Even without adoption by other healthcare entities, these unofficial standards may have an *in terrorum* effect on the healthcare professionals being regulated, forcing them to self-adopt a requirement that limits competition for fear of disciplinary action. As discussed *infra* in Part III, these informal board activities are particularly pernicious since they often avoid any material public review or comment and are not usually amenable even to procedural challenge under the state's administrative procedures act.

B. Professional Regulatory Board Actions Can Restrain Competition from Qualified Competing Providers.

As the findings in this case reflect, unreviewed board activities falling short of rulemaking or an appealable adjudicatory decision can and do have the effect of forcing competitors in the healthcare field to exit the market. *N.C. Bd. Dental Exam'rs*, 717 F.3d at 365. Cease and desist letters of the sort utilized in this case are an example of the sort of board activity that has the capacity to automatically thwart competition without legal challenge. A party receiving such a letter reasonably may conclude that they face an immediate threat of disciplinary action or criminal penalty. Options for avoiding these consequences are limited and expensive. Administrative procedure acts do not typically provide a right of review of a cease and desist letter, and where state law affords an action for declaratory judgment, the expense and uncertainty of undertaking that litigation is sufficient itself to forestall the competitive healthcare provider.

Professional boards are well aware that the threat of criminal penalties or disciplinary action is a potent weapon for eliminating competitors. Members of *amici* nursing organizations have firsthand experience with the impact of cease and desist letters and investigations of physicians and nurses which cause nurses in general, and specifically APRNs, to cease providing certain types of care within their scope of practice or which cause physicians to disassociate from nurses providing the service, even without a board hearing. Healthcare

professionals often choose to stop practicing in an area of their expertise when faced with such allegations to avoid the financial costs of legal representation, the disruption to other elements of their practice, or the potential harm to their reputation as a result of a board hearing.

This Court has recognized the danger that private professional, trade or industry guilds or boards will not only be concerned with public safety issues, but may at the same time act to protect their members' positions *vis a vis* competitors, including by restricting those competitors from the marketplace. As noted by Justice Stevens:

> A potential conflict arises . . . whenever government delegates licensing power to private parties whose economic interests may be served by limiting the number of competitors who engage in a particular trade. In fact, private parties have used licensing to advance their own interests in restraining competition at the expense of the public interest.

Hoover v. Ronwin, 466 U.S. 558, 584 (1984) (Steven, J., dissenting) (citing Walter Gellhorn, *The Abuse of Occupational Licensing*, 44 U. Chi. L. Rev. 6 (1975)).

Independent studies of healthcare regulatory boards have also observed the tendency of such boards to make decisions, not otherwise sufficiently justified by safety concerns, to entrench and protect the power of the profession being regulated at the expense of patients and potential competitors. *See* Dower & Finocchio, *supra*, at 422; Gary L. Gaumer, *Regulating Health Professionals:*

A Review of the Empirical Literature, Milbank Memorial Fund Q./Health and Soc'y, Summer 1984, at 408-09 (referencing "overwhelming support[] in the literature, that the public interest will continue to be compromised in favor of professional interests as long as boards are dominated by professions"); Taskforce on Health Care Workforce Regulation, Pew Health Professions Comm'n, *Strengthening Consumer Protection: Priorities for Health Care Workforce Regulation* 2 (1998) [hereinafter Pew Taskforce Report] ("The ostensible goal of professional regulation—to establish standards that protect consumers from incompetent practitioners—is eclipsed by a tacit goal of protecting the professions' economic prerogative.").[4]

The negative impact of scope of practice decisions by healthcare professional boards on patient access to competing health providers with overlapping expertise and on innovation in healthcare delivery has been widely recognized. IOM Report, *supra*, at 102 ("Current laws are hampering the ability of APRNs to contribute to innovative health care delivery solutions."); *see* AARP, *AARP 2010 Policy Supplement: Scope of Practice for Advanced Practice Registered Nurses* (2010). (In March 2010, the board of directors of AARP concluded that statutory and regulatory barriers at the state and federal levels are short-changing consumers.);[5] Dower & Finocchio, *supra*, at 423. Patients are harmed where access to care is unnecessarily restricted, particularly in

---

[4] *Available at* http://futurehealth.ucsf.edu/Content/29/1998-12_Strengthening_Consumer_Protection_Priorities_for_Health_Care_Workforce_Regulation.pdf.

[5] *Available at* https://flanp.org/files/2010-AARPPolicy SupplementScopeofPractice.pdf.

rural areas or where the shortage of primary care physicians is acute. In its 2011 report on "The Future of Nursing," the Institute of Medicine urged states to closely examine their scope of practice laws to afford the broadest possible use of nursing professionals in our healthcare system and noted that states removing artificial barriers "have experienced no deterioration of patient care." IOM Report, *supra*, at 9-11, 114. *Amici* nursing associations acknowledge the state's prerogative to limit competition in nursing practice or other healthcare disciplines, but absent "active state supervision," decisions of majority practitioner staffed boards pose the risk that competition will be impaired beyond what was intended by the states, exacerbating problems of access to quality healthcare or unnecessarily increasing costs as a result of reduced competition in the healthcare market. A considered review by state authorities responsible for public healthcare budgets is vital to addressing public health needs efficiently and safely by maximizing competitive workforce options where possible.

C. The Danger of Anticompetitive Board Actions Arises Where Market Participants Control the Board Irrespective of the Method of Their Selection.

Amici nursing associations and the CAC agree with views expressed by *amici* supporting reversal that any anticompetitive danger identified in the Fourth Circuit decision arising from majority practitioner staffed boards is present irrespective of the method of

selection of those members.[6] The fact that the members of the Dental Board were elected exclusively by fellow market participants without any state involvement underscores the purely private nature of the Dental Board, but private election is not essential to creating the risk that a practitioner staffed board will work to protect its own economic interest at the expense of competition and the public welfare. Market participants have an interest in protecting their own competitive position whether elected by peers or appointed by a government official.

In fact, the form of private selection of the Dental Board members is rare in the context of medical and nursing boards. Only one state board of medicine (Alabama) is constituted through elections by practicing physicians, and only one state board of nursing (North Carolina) provides for private election by nursing professionals. *See* Fed'n of State Med. Bds., *U.S. Medical Regulatory Trends and Actions* 45 (2014) [hereinafter FSMB *Trends and Actions*];[7] Nat'l Council of State Bd. of Nursing, *Board Structure* 13-14 (2012) [hereinafter NCSBN *Board Structure*].[8] Much more common are medical and nursing boards constituted by Governor appointment. Nearly all state boards regulating registered nurses and state boards of medicine are constituted with a majority of practicing

---

[6] *See* Brief for Federation of State Boards of Physical Therapy et al. as Amici Curiae Supporting the Petitioner at 12; Brief for North Carolina State Bar et al. as Amici Curiae Supporting the Petitioner at 18-19; Brief for State of West Virginia and 21 Other States as Amici Curiae Supporting the Petitioner at 11 n.20.

[7] *Available at* http://www.fsmb.org/Media/Default/PDF/FSMB/Publications/us_medical_regulatory_trends_actions.pdf.

[8] *Available at* https://www.ncsbn.org/Board_Structure.pdf.

professionals, appointed by the Governor.[9] *See* FSMB *Trends and Actions*, *supra*, at 43, 45; NCSBN *Board Structure*, *supra*, at 7-9. In order to fully address the underlying risk that these boards may take anticompetitive action not reflective of the state's intended policy, *amici* nursing associations and the CAC urge that the Fourth Circuit's decision be affirmed in a manner that recognizes the risk of board activity where the board is controlled by a majority of market participants, irrespective of the method of their selection.

At a minimum, however, the Fourth Circuit decision must be affirmed to the extent it applies to state regulatory boards that are controlled by market participants who are elected to serve by their peers, themselves market participants, without any state involvement in the selection process. Petitioner does not contest for purposes of this appeal that whatever minimal state procedural rules or standards apply to the Dental Board, those mechanisms do not constitute "active state supervision" under this Court's jurisprudence. Brief of Petitioner at 9. Granting the Dental Board the benefits of state action immunity would run directly counter to precedent forbidding the state to surrender regulatory authority to private parties with an economic interest in the regulations without maintaining active oversight. *See, e.g.*, *Ticor Title*, 504 U.S. at 633-35; *Midcal*, 445 U.S. at 105.

---

[9] According to statistics calculated using the data in NCSBN *Board Structure* and FSMB *Trends and Actions* surveys, greater than ninety-five percent of both state boards regulating registered nurses and state boards of medicine are composed of a majority of those practicing in the profession and are Governor appointed.

II. MAJORITY STAFFED PROFESSIONAL BOARDS DO NOT POSSESS THE SALIENT ATTRIBUTES OF A MUNICIPALITY.

The Fourth Circuit declined to apply the holding in *Hallie* to the activities of the Dental Board because it found *Hallie* "inapplicable . . . where the 'state agency' is composed entirely of private market participants." *N.C. Bd. of Dental Exam'rs*, 717 F.3d at 367 n.4. Petitioner urges this Court to reverse that holding to treat a majority practitioner staffed board as a sub-state authority equivalent to a municipality. *Amici* nursing associations and the CAC disagree with Petitioner that the test for "state action" set forth in *Hallie* is appropriately applied to majority practitioner staffed boards because municipalities and professional regulatory boards share few, if any, relevant attributes.

Hallie recognized that municipalities are distinguishable from other entities charged by the state with authority to regulate because "a municipality is an arm of the State." *Hallie*, 471 U.S. at 45. Contrasting municipalities with private parties who "may be presumed to be acting primarily on his or its own behalf," this Court concluded that it could presume "that the municipality acts in the public interest." *Id.* Salient to that determination was the acknowledgement that municipal activity "is invariably more likely to be exposed to public scrutiny than is private conduct" and that the electoral process "checked to some degree" activities of municipal officers. *Id.* at 45 n.9.

Practitioner staffed regulatory boards do not possess the same broad and competing interests as municipalities and are not subject to the same public accountability mechanisms. Unlike municipal officials, state board members are not publicly elected. Insofar as board members may be appointed by the Governor, the public is not generally knowledgeable about board appointments, and board appointments are highly unlikely to be determinative of, or even remotely relevant to, the average voter's decision in the polling booth. To presume any sort of indirect "electoral check" on board members would be folly.

Members of healthcare professional boards typically operate with significant independence from the state. The ties between part-time professional board members and the state are tenuous at best. As *amici* urging reversal have noted, members serving on professional boards often volunteer their time or are paid only a token amount for their service. They do not rely on the state for their livelihood. Market participant board members are private economic actors deriving their income from their own practice and effectively contributing their time to the board as an activity ancillary to their daily occupation.

Public review of professional board activities also differs significantly from the public's access to information regarding a municipality. State regulatory boards do not receive the sort of public attention and scrutiny as do municipal officials. Activities of professional boards, usually concerning the scope or standards of practice, licensing or discipline, rarely attract widespread public attention. While municipalities are regularly covered in the mainstream press,

professional board activities are not typically the subject of press coverage, except for trade press directed to the regulated practitioners.

Amici supporting Petitioner cite to the existence of certain reporting functions and open government requirements as a basis for analogizing a board to a publicly scrutinized municipality. While professional boards may be required to follow certain open meeting and procedural rules, in *amici's* experience, meetings of healthcare professional boards rarely attract any participants beyond the regulated professionals themselves. *See* Pew Taskforce Report, *supra*, at 10 ("Despite open meeting laws, board processes are generally unknown to the public."). Given the specialized nature of board issues, open meeting rules provide no meaningful opportunity or incentive for the public to act as a significant check on board actions.

Petitioner references the annual report of the Dental Board to executive branch officials of North Carolina as evidence that the Dental Board's activities qualify as "state action." Brief of Petitioner at 6-7. Typical board reporting requirements, like those in North Carolina, fail to provide the sort of prophylactic scrutiny necessary to justify the absence of "active state supervision." *See* N.C. Gen. Stat. § 90-44 (end-of-year reporting of fees, expenses, examinations and hearings); N.C. Gen. Stat. § 93B-2 (end-of-year reporting of licensure and examination statistics and general activities of the board). Statutes requiring regulatory board reports often provide no definition of required report content or, if they do, focus heavily on the reporting of statistics regarding licensure or finances. *See* Mass. Gen. Laws ch. 112, § 78 (unspecified reporting

on "condition of nursing"); Tenn. Code Ann. § 63-7-207 (unspecified reporting plus disclosure of receipts and disbursements). This sort of *ex post facto* annual reporting is not designed to forestall overreaching board decisions. Without mechanisms that insure meaningful substantive and contemporaneous review that permits corrections before enactment or enforcement of board actions, these reports do little to satisfy the need for state or public accountability of boards sufficient to warrant the abandonment of "active state supervision."

The rationale underlying this Court's decision in *Hallie* to relieve municipalities of showing "active state supervision" does not apply to majority healthcare practitioner staffed regulatory boards, consisting of self-elected or appointed market participants operating in a specialized and obscure area of state government without any meaningful public scrutiny, without sufficient public or government accountability or electoral check on their activities, and when the controlling board members owe their economic allegiance to their own professional practice, not the state.

III. CONSUMERS AND MARKET PARTICIPANTS ARE NOT PROTECTED FROM UN-AUTHORIZED ANTICOMPETITIVE ACTIONS OF STATE BOARDS BY EXISTING PROCEDURAL STATUTES OR ETHICAL RULES.

Amici in support of reversal contend that the public is sufficiently protected from unauthorized anticompetitive actions of professional boards by virtue of state procedural laws and ethical standards governing board members. While these laws concededly police certain abuses of state professional boards, they are not designed to remedy and do not address concerns for preserving competitive markets.

Ethical standards that may be applicable to state board members are designed to protect against corruption and other behaviors that undermine the integrity of democratic processes, such as nepotism, bribery and self-dealing. *See* N.C. Gen. Stat. § 138A *et seq.* (requiring that officials exercise their authority honestly and fairly, free from impropriety, threats, favoritism and undue influence, and forbidding bribery and use of public position or information for private gain); *see also* Alaska Stat. § 39.52 *et seq.* (prohibiting action upon personal or financial interest, misuse of official position for personal gain, bribery and disclosure of private information); La. Rev. Stat. Ann. § 42:1101 *et seq.* (forbidding unauthorized practices, including bribery, nepotism and self-interested transactions); W. Va. Code Ann. § 6B-2-5 (forbidding use of public office for private gain, bribery and use of confidential

information for personal interests or interests of another). These ethical standards are intended to proscribe behavior that advances a person's individual financial interests, not to identify decision making that protects a general economic interest of the regulated group.

Nor do ethical rules examine issues of state policy or the scope of a regulatory board's authority. Insofar as these ethical canons are also cited as being indicative of board members' status as state officers, they provide no evidence that a board member acting consistent with state ethics standards is also actually effecting the policy of the state to displace competition. Private associations of healthcare providers also adopt ethical standards of practice that members are advised or required to follow. Those ethical standards no more insulate individual members from antitrust scrutiny than should governmental ethical standards. *See, e.g.*, *California Dental Ass'n v. FTC*, 526 U.S. 756 (1999) (evaluating legality of ethical rules for advertising under FTC Act); *Nat'l Soc'y of Prof'l Eng'rs*, 435 U.S. 679 (finding ethical rules regarding communications on price in violation of the Sherman Act); *Goldfarb*, 421 U.S. 773 (rejecting state action immunity for bar ethical rules setting minimum fees).

Like ethical canons, the utility of state administrative procedure acts to protect consumers or competitors from anticompetitive board activities is inherently circumscribed. Standing to challenge an agency action under these statutes is usually limited to appeals of final rules and final agency decisions. *See, e.g.*, Ark. Code Ann. §§ 25-15-207, 212; Mass. Gen. Laws ch. 30A, §§ 7, 14; W. Va. Code §§ 29A-4-2, 5-4. Falling

outside the purview of most administrative procedure acts are the very sorts of activities that worked to eliminate competition in this case.

A cease and desist letter, like the ones issued by the Dental Board, is neither a final agency decision nor a formal rulemaking with a corresponding right of review. Policy statements, guidelines or advisory opinions also generally carry no right of review but, nevertheless, can have a profoundly chilling effect or dramatic anticompetitive impact on the marketplace. These typical board activities escape the procedural requirements of notice, hearing and comment, imposed by most state administrative acts. When a policy statement or guidance places additional requirements or limitations on the practice of competitive healthcare providers, including requirements for "supervision," they are often adopted by healthcare facilities and insurers in a manner that proscribes competition but does not permit a challenge under administrative procedure acts. *See* N.C. Gen. Stat. § 150B-2 (excluding from the definition of reviewable "rule" any "nonbinding interpretive statements" or "statements of agency policy"). Administrative procedures acts are not, in any event, designed to address issues of competition, and often judicial review of agency action grants deference to the agency due to its presumed expertise in the subject area. *See, e.g.*, Del. Code Ann. tit. 29 § 10141(e) (requiring that the "agency action shall be presumed to be valid" and directing courts additionally to "take due account of the experience and specialized competence of the agency"); Mass. Gen. Laws ch. 30A, § 14(7)(g) (requiring that the "court shall give due weight to the experience, technical competence, and specialized knowledge of the agency, as well as to the discretionary

authority conferred upon it"). Administrative procedure act appeals are a poor substitute for antitrust enforcement[10] and cannot offer the same rigorous and regular review that "active state supervision" would provide.

IV. STATES ARE CAPABLE OF PROVIDING ADEQUATE SUPERVISION OF PROFESSIONAL BOARDS AND CAN RETAIN THE BENEFIT OF THE PARTICIPATION OF PROFESSIONALS ON REGULATORY BOARDS IF THE DECISION IS AFFIRMED.

Members of *amici* nursing associations serve on boards of nursing across the country and endorse the value and necessity of professional expertise on healthcare professional regulatory boards. Healthcare practitioners provide invaluable insight and knowledge on questions relating to quality, safety and the practicality of rules or standards, based on their intimate knowledge of current technology and practice.

---

[10] Unlike federal antitrust laws which support the enforcement activities of private plaintiffs by virtue of provisions for attorneys' fees and treble damages, administrative procedure acts offer no support for consumers or competitors to mount expensive and daunting legal challenges to agency actions. *See* 15 U.S.C. § 15. In states where board actions are presumptively valid, individuals challenging a board action also face heightened burdens of proof not required of antitrust plaintiffs.

Amici nursing associations and the CAC disagree with *amici* supporting reversal, however, that "active state supervision" of such boards would undermine their efficacy[11] or that state supervision would otherwise be impracticable. States already recognize the value of including independent members on healthcare professional boards. The large majority of states require one or more consumer, public or other non-professional representative on their boards regulating registered nurses and on their boards of medicine.[12] *See* FSMB *Trends and Actions*, *supra*, at 43; NCSBN *Board Structure*, *supra*, at 9. In order to ensure the independence of these members, most state boards regulating registered nurses prohibit these individuals from involvement or interests in the healthcare industry.[13] *See* NCSBN *Board Structure*, *supra*, at 24-45.

---

[11] *Amici* nursing associations and the CAC acknowledge that the state agency providing oversight must not also be controlled by practicing healthcare professionals. Otherwise, the establishment of an oversight agency would merely change the locus of the problem of professional entrenchment. For example, the creation of state umbrella boards controlled by practicing healthcare professionals may even aggravate the problem by consolidating authority in the hands of practicing healthcare professionals.

[12] According to statistics calculated using the data in NCSBN *Board Structure* and FSMB *Trends and Actions* surveys, greater than ninety percent of boards of medicine and greater than seventy percent of boards regulating registered nurses require at least one member designated as a consumer or public representative.

[13] According to statistics calculated using the data in NCSBN *Board Structure* survey, more than seventy percent of boards regulating registered nursing with a consumer or public representative place limitations on the member's healthcare interests in or association with healthcare businesses.

Contrary to claims by *amici* supporting reversal, independent state oversight of boards of nursing is not a novel concept. A number of states provide for oversight of nursing board activities by a state agency. *See, e.g.*, Conn. Gen. Stat. Ann. §§ 20-90, 96, 99a (Department of Public Health adopts regulations and approves nursing programs with advice and assistance from the Board); 225 Ill. Comp. Stat. 65/50-65 (Department of Financial and Professional Regulation adopts and revises rules, approves or denies nursing education programs, and conducts disciplinary actions with the recommendation of the Board); Utah Code Ann. § 58-31b-201 (Division of Occupational and Professional Licensing determines standards for education programs and reviews complaints of unprofessional conduct with recommendation from the Board).

The notion that the states lack relevant expertise in healthcare matters is unfounded. State departments of health and similar agencies, staffed with public health professionals, are amply qualified to consider and review issues regarding healthcare professional licensing and scope and standards of practice. Indeed, experts considering how to enhance the quality of healthcare professional regulation have endorsed the involvement of state health agencies in the regulatory process to diminish the tendency of healthcare professional boards to self-protect. *See* Gaumer, *supra*, at 408 (discussing recommendations of enhancing state agency involvement in professional regulations of boards to improve efficacy); Pew Taskforce Report, *supra*, at 14. Some experts regard state departments of health as particularly suited to improve healthcare regulatory regimes by virtue of their experience, and the expertise

of staff public health professionals, in evaluating empirical evidence of healthcare and healthcare delivery outcomes and assessing broad public healthcare needs. *See* Dower & Finocchio, *supra*, at 423-26 (identifying and recommending public health agencies and public health professionals as competent to review and handle scope of practice issues).

Legislators likewise are capable of providing oversight. The very licensing and healthcare scope of practice acts enforced by the boards are drafted and passed by layperson legislators, with the benefit of testimony and advice of professionals. Many of these statutes address highly technical procedures and the use of devices unfamiliar to the average legislator. Indeed, federalism principles dictate that the legislators, regardless of their expertise or knowledge, effect the will of the sovereign state.

While *amici* nursing associations and the CAC agree that practicing healthcare professionals are necessary to evaluate these issues, layperson legislators, state agency employees and public board members can and should participate in these decisions. Putting aside the competencies of non-healthcare practitioners to participate or oversee board decisions, the function of the "active state supervision" requirement for purposes of the court's review is merely to insure that the action taken comports with the state's intended policy to displace competition. As this Court has recognized:

> The active supervision requirement stems from the recognition that where a private party is engaging in the anticompetitive activity, there is a real

> danger that he is acting to further his own interests, rather than the governmental interests of the State . . . The requirement is designed to ensure that the state-action doctrine will shelter only the particular anticompetitive acts of private parties that, in the judgment of the State, actually further state regulatory policies.

Ticor Title, 504 U.S. at 634 (internal quotation marks omitted).

The issue under this Court's jurisprudence is not whether the state's decision is effective, sound or advisable, but whether, in fact, the action is the state's decision. *Id.* at 634-35 ("Our decisions make clear that the purpose of the active supervision inquiry is not to determine whether the State has met some normative standard, such as efficiency, in its regulatory practices."). No special or technical expertise is required of the state to determine whether the board action is consistent with the policy to displace competition adopted by the state. *See Hoover*, 466 U.S. at 569 ("The Court did not suggest in *Parker*, nor has it suggested since, that a state action is exempt from antitrust liability only if the sovereign acted wisely after full disclosure from its subordinate officers. The only requirement is that the action be that of the State acting as a sovereign.") (internal quotation marks omitted).

Affirming the Fourth Circuit decision should not force the states to abandon reliance on the knowledge and expertise of practicing professionals subject to state regulation. States should be able, in *amici's* view, to

continue to staff healthcare professional boards with a majority of the regulated professionals while also insuring through "active state supervision" that the decisions of the board accurately reflect the policy of the state.

CONCLUSION

When the sovereign state chooses to delegate its regulatory authority to private economic actors, the doctrine of state action immunity requires a closer examination of the true nature of the state sanctioned entity and closer review by the state. The Fourth Circuit correctly deemed the North Carolina Board of Dental Examiners, privately controlled and elected by market participants, a private actor vested with regulatory authority by the state and requiring that it both act consistent with a "clearly articulated and affirmatively expressed" state policy to displace competition and with the benefit of "active state supervision." Professional regulatory boards controlled by actively practicing professionals are not analogous to municipalities for purposes of state action immunity. These majority practitioner boards lack any electoral check or any meaningful public review of their activities and, unlike municipalities, possess the incentive to protect entrenched private economic positions *vis a vis* potential competitors, harming consumers by their decisions. State supervision of these professional boards is feasible and appropriate. Reversal of the Fourth Circuit decision would doctrinize a loophole in antitrust enforcement, permitting states to surrender legislative power to market participants selected exclusively by other market participants without any assurance that

the board is acting consistent with state policy, merely by designating the board a "state agency."

Respectfully submitted,

KATHRYN K. CONDE
Counsel of Record
HILARY S. BLACKWOOD
NUTTER MCCLENNEN & FISH, LLP
155 SEAPORT BOULEVARD
BOSTON, MA 02210
(617) 439-2000
kconde@nutter.com

Counsel for Amici Curiae