The American Board of Medical Specialties: Certification and The Need for Antitrust Enforcement

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Biography

Adam Candeub is a professor of law at Michigan State University where he teaches and researches regulatory and competition issues. Prior to entering academics, he worked in private practice in Washington, D.C. as well as at the Federal Communications Commission, where he focused on regulatory matters relating to antitrust and market power. He served as Deputy Assistant of Commerce for the National Telecommunications and Information Authority and Deputy Associate Attorney General under President Trump. He has published widely on antitrust and in healthcare regulation in journals such as the Georgia Law Review and the Wake Forest Law Review.

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Executive Summary: What is Certification and Why Does it Matter to Healthcare?

Certification serves as medicine's gatekeeper. Certifying organizations ensure that their physicians meet the appropriate professional standards. Traditionally, numerous organizations have provided certification services, which often involve costly testing and examinations. Physicians and other medical professional seek and obtain certification throughout their careers. Medical schools, residency programs, boards that recognize specialty physician skills ("Board certification"), and continuing medical education (CME) are all certification processes. Certification and CME impose huge costs on the healthcare system. For example, the American Board of Internal Medicine (ABIM), which certifies internists and other subspecialties, revealed that the organization had nearly $100 million in revenue and an investment portfolio of $84.5 million as of June 30, 2023.[1] CME is reported to become a $4.23 billion industry within this decade,[2] an industry that coupled with the ACGME, the ABMS is reportedly seeking to expand into.

Competition among organizations providing these certification services drives innovation and lowers healthcare costs. The domination of the American Board of Medical Specialists (ABMS) over certification is dramatically raising certification costs and indirectly accreditation costs throughout medicine, decreasing access to physicians, increasing already exploding medical budgets, and reducing healthcare innovation. The tragic COVID-19 pandemic underscores how market power in certification undermines patient access to healthcare. Numerous reports indicate that hospitals, particularly in New York City and Michigan where the pandemic had some of its

[1] The American Board of Internal Medicine and Affiliated Foundation Consolidated Financial Statements and Supplementary Information Years Ended June 30, 2023 and 2022, https://tinyurl.com/4ne4nbjx.
[2] Business Wire, United States Continuing Medical Education Market Outlook Report 2023: A $4.23 Billion Market by 2028 (Aug. 23, 2023), https://tinyurl.com/39hkx954.

greatest impact, rejected physicians volunteering to serve solely because they had a certification from an organization other than ABMS's American Board of Emergency Medicine, such as its smaller competitor the American Board of Physician Specialties (ABPS).

In addition, within our military, the ABMS appears to exert a disturbing level of influence over personnel decisions. Over the past few years, the Department of Defense's (DOD) Defense Health Agency (DHA), the entity that directs nearly all of the military's healthcare system, has started to require physicians to be board certified by an ABMS-affiliated board. This decision has had a disastrous effect upon the quality of healthcare that our servicemen and women can access.

For instance, in June 2022, highly military ranked physicians with over 20 years of experience within the Army came forward to describe the difficulty they were having in getting credentialed due to having become board certified by ABMS. These physicians chose to be board certified by the ABPS's Board Certification in Emergency Medicine (BCEM) and the American Board of Disaster Medicine. One of these physicians was delayed for deployment in Syria due to complications arising from acceptance of his non-ABMS board certification. The removal of even one physician from where our military are on mission places the lives of our servicemen and women at risk.

Leveraging its dominant market position in certification, ABMS and its member boards are now extracting even more revenue from physicians by requiring not simply periodic recertification exams to maintain board membership but continuous participation in maintenance of certification (MOC) programs–which ABMS claims to have revamped but still remain very costly to physicians and the institutions where they work. Physicians with specialty board certifications must undergo a rigorous exam process to gain certification, and typically, after certification, boards require periodic recertification every eight to ten years depending on the specialty. MOC programs, on the other

hand, typically involve continuous educational and quasi-educational activities. Careful empirical analyses have shown that these programs do not correlate with measurable improvements in health care despite their great cost both in money and physician time.

ABMS (a non-profit entity) and its 24 member boards dominate this billion dollar/year certification service industry, making certification more burdensome to doctors and extremely profitable for themselves. This is, of course, objectionable, but what is worse is that they shut out other, highly respected organizations that provide the same services. ABMS resorts to seeking special treatment from Medicare, medical boards, insurance and hospitals, and other accreditation organizations in order to retain and strengthen its hold on physician certification and limit competition and innovation.

For instance, the Accreditation Council for Graduate Medical Education (ACGME) accredits residency programs, making them eligible for $10 billion per year in direct federal support. ACGME, however, only recognizes programs that lead to board certification by the ABMS, essentially shutting out all competitors from providing certification testing and exam services, exacerbating the physician shortage and raising compliance costs. This policy appears to be incorporated into its Clinical Learning Environment Review (CLER) program.[3] The ACGME's and ABMS's close, interlocking board structure, along with the ABMS being a co-founder of the ACGME, could explain this behavior which is so hostile to competition.

Last, ABMS's growing power is spreading beyond certification. Its influence has appeared to lead to hospitals only granting privileges to, and even insurance companies only reimbursing, ABMS-certified physicians. Inexplicably, the Defense Health Agency, which directs healthcare for the entire U.S. military, only recognizes ABMS board certification. State medical boards of

[3] Accreditation Council for Graduate Medical Education, Physician Licensing and Certification, https://www.acgme.org/about/physician-licensing-and-certification/.

medicine, under ABMS's sway, are adopting and advocating policies that only favor ABMS-certified physicians – even though in early 2023, the American Medical Association (AMA) passed Resolution 36-I-22, which states that they will advocate that federal agencies and others must update their certifying bodies beyond just ABMS/AOA and identifies other recognized physician certifying entities. These current policies will only cement ABMS's market power and drive up healthcare costs, as physicians pass on the cost of their certification testing to patients and the government. Access to physicians will further decline, exacerbating the problem medical care availability, particularly in rural America.

But, the tide is turning. ABMS's abuse of its market power affects not only patients through decreased access to lower quality, higher priced healthcare but also harms physicians. They must pay for the certification processes in both time and money. They have realized the importance of competition in certification. The American Medical Association, which in fact founded in 1933 the now independent ABMS, has carefully reviewed certifying bodies in a recent report by its Council on Medical Education. It concluded that other certifying bodies, such as the ABPS, "should not be discriminated against for purposes of measuring quality of care, determining eligibility to contract with managed care entities, eligibility to receive hospital staff or other clinical privileges, ascertaining competence to practice medicine, or for other purposes."[4] The Council on Medical Education's creates an evidence-based rubric to analyze certifying bodies. It shows that ABPS and other groups, provide services at the highest levels, at least equal to that of ABMS.

[4] CME Report 4-I-23, Recognizing Specialty Certifications for Physicians (Resolution 3l6-l-22) at 11.

I. Introduction

According to the Centers for Medicare & Medicaid Services healthcare costs "grew 4.6 percent in 2018, reaching $3.6 trillion or $11,172 per person."[5] Healthcare spending now accounts for 17.7 percent of the nation's Gross Domestic Product.[6] Looking at this increase more granularly, spending on physician and clinical services increased 4.1 percent to $725.6 billion in 2018.[7] In addition, the Centers for Medicare & Medicaid Services project the overall cost of healthcare to rise to nearly 20% of the U.S. GDP by 2025.[8] The American Board of Medical Specialties (ABMS), through its efforts to maintain its monopoly in multiples areas of certification and even accreditation, drives much of this rise in costs.

Despite partisan disagreements over healthcare policy, both Democrats and Republicans agree that healthcare costs are exorbitant, and their rates of increase needs to slow. For example, Elizabeth Warren's healthcare plan aims to reduce costs by increasing antitrust scrutiny on hospitals and reducing insurance and administrative costs.[9] President Trump signed an executive order in 2017 which sought "to focus on promoting competition in healthcare markets and limiting excessive consolidation throughout the healthcare system."[10] In 2019, he signed another executive

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[5] Center for Medicare & Medicaid Services, *National Health Expenditure Data: Historical*, *available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-reports/NationalHealthExpendData/NationalHealthAccountsHistorical.
[6] *Id.*
[7] *Id.*
[8] Center for Medicare & Medicaid Services, 2016-2025 Projections of National Health Expenditures Data Released, *available at* https://www.cms.gov/newsroom/press-releases/2016-2025-projections-national-health-expenditures- data-released.
[9] *Healthcare is a Basic Human Right*, https://elizabethwarren.com/plans/health-care (accessed Jan. 19, 2020).
[10] *Presidential Executive Order Promoting Healthcare Choice and Competition Across the United States* (Oct. 12, 2017), *available at* https://www.whitehouse.gov/presidential-actions/presidential-executive- order-promoting-healthcare-choice-competition-across-united-states/.

order, noting the importance of "lower cost providers" and "eliminating these impediments in a way that promotes competition."[11]

The 2015 Supreme Court case, *FTC v. North Carolina State Board of Dental Examiners* (*North Carolina Dental),*[12] ruled that licensing boards in the healthcare professions receive antitrust scrutiny. This decision garnered support from groups as diverse as the libertarian Cato Institute, the conservative Heritage Foundation, and the progressive American Antitrust Institute.[13] These groups see antitrust enforcement in healthcare as key to lowering costs, increasing patient access, and encouraging innovation.

The ABMS's anticompetitive conduct—engaged in coordination with other medical, accrediting and certification boards, state governments, federal agencies, insurance companies, and hospitals— touches on these concerns that resonate on all sides of the political spectrum. To take one pressing example, the ABMS's role in residency accreditation unreasonably restricts the number of available medical student matches and depresses the nation's physician supply, decreasing access and raising costs for patients. Taxpayers all bear these costs, as, according to the Congressional Research Service, the federal government spends approximately $16 billion a year on subsidizing graduate medical education, which is ultimately governed by the ACGME.[14]

Further, ABMS's monopolistic dominance in the billion-dollar certification services industry has led to maintenance of certification (MOC) programs that are more burdensome to physicians in terms of time and money as well as more profitable for ABMS and its member

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[11] Executive Order on Improving Price and Quality Transparency in American Healthcare to Put Patients First (June 24, 2019), *available at* https://www.whitehouse.gov/presidential-actions/executive-order-improving-price-quality- transparency-american-healthcare-put-patients-first/

[12] 574 U.S._____(2015), 135 S. Ct. 1101 (2015).

[13] *North Carolina Board of Dental Examiners v. Federal Trade Commission*, SCOTUS BLOG, *available at* https://www.scotusblog.com/case-files/cases/north-carolina-board-of-dental-examiners-v-federal-trade-commission/ (list of links to groups' amicus briefs).

[14] Elayne J. Heisler, et. al, *Federal Support for Graduate Medical Education: An Overview*, CONG. RES. SERV. (Dec. 27, 2018), *available at* https://fas.org/sgp/crs/misc/R44376.pdf.

boards. Certifying boards typically require periodic examinations to recertify. These exams are usually required every eight to ten years depending on the specialty. Taking recertification to a new level, however, ABMS and its member boards have successfully pushed for the adoption of Maintenance-of- Certification (MOC) training, i.e., required programs for practicing doctors to maintain their certification. Becoming the ubiquitous, never finished homework of modern medicine, MOCs require physicians to be continuously enrolled (and paying for) educational programs not proven to improve patient safety and care. While difficult to calculate, the cost of MOCs reflects billions of dollars not simply in terms of fees paid to ABMS and its member boards, but in physician time and opportunity costs. Not surprisingly, ABMS pursued MOC-adoption despite fierce opposition from the American Medical Association.[15]

While the investment would certainly be worthwhile if MOC programs improved patient outcomes or made healthcare delivery more efficient, the evidence suggests otherwise. As one example, a 2015 study appearing in the Annals of Internal Medicine examined the MOC administered by the American Board of Internal Medicine (ABIM). This Board is *only one* of the twenty-four member boards constituting ABMS. The ABIM MOC imposes $5.7 billion on physicians over a ten period. (Sandhu, 2015) These costs are passed onto patients and are often paid directly by Medicare, contributing to ABMS's and its members' billion-dollar yearly revenue.[16] It is far from clear that ABMS's MOC programs improve physician performance. Rather, "the new MOC requirements are backed with little or no scientific data to justify their imposition [because] . . . little if any scientifically documented data support[s] many of the ABIM's

[15] *Response to the American Medical Association Policy on Secure Recertification Exam*, AM. BD. OF MED. SPECIALTIES (Jun. 17, 2016), *available at* https://www.abms.org/media/119898/response-to-ama-policy-on-secure-recertification-examination.pdf

[16] Alexander T. Sandhu et al., *A cost analysis of the American Board of Internal Medicine's Maintenance-of- Certification Program*, 163 ANNALS OF INTERNAL MEDICINE 401 (2015).

previous decisions."[17]

ABMS's behavior and policies go beyond raising prices or imposing unjustified costs to actually endangering American lives—as the COVID-19 pandemic demonstrates. Hospitals, particularly in the New York City area and southwestern Michigan, where the disease had its greatest impact, have a tremendous need for additional physicians. But, numerous reports indicate that the major hospitals in these areas are *refusing to consider* non-ABMS certified physicians who are offering to work. These hospitals are refusing to hire some of the most highly qualified emergency physicians—with long and distinguished professional records who want to help their fellow Americans during this crisis—simply because they hold certifications from a non-ABMS certifying body.

Furthermore, the Defense Health Agency's (DHA) arbitrary decision, discussed below, to restrict the supply of physicians able to serve reduces our military's access to medical care. For example, the advanced specialty of integrative medicine has been the main focus for the Department of Veterans Affairs for some time. These physician specialists focus on effective alternatives to opioids and have worked to integrate eastern methodologies with western clinical care. This medical approach has proven to be effective in reducing the need for opioids and having impactful approaches to addiction, PTSD, and other maladies. Integrative Medicine takes the lead in combatting opioids and has seen great results in managing PTSD through controlled psychedelics. Yet, specialists such as these, which are sorely needed can no longer serve in our military for the American Board of Integrative Medicine is a certifying body led by a volunteer ABPS-based organization. The American Board of Integrative Medicine is a David to ABMS's

[17] W. G. Fisher & E. J. Schloss, *Medical specialty certification in the United States—a false idol?* 47 JOURNAL OF INTERVENTIONAL CARDIAC ELECTROPHYSIOLOGY 37 (2016).

Goliath. Was the focus truly on patient safety and care, DHS would welcome high quality specialists who can approach the medical challenges of our servicemen and women from innovative and creative perspective.

Other vitally important specialties to our military are also being kept out, including but not limited to boards of certification under the American Podiatric Medical Association, or singular certifying bodies such as the American Board of Pain Medicine. One would think that given the podiatric issues our military face with the constant wear of combat boots in humid and challenging weather conditions where they are on mission, that we would not only allow for these specialists but encourage their recruitment into our military. In addition, with the diversity of our military and a high percentage of those serving being of African American or Latino decent, maladies such as diabetes are prevalent. One of the most important specialties most often used by diabetics is podiatric medicine, yet current policy implemented by ABMS-certified physician leaders within DHA does not allow for such specialists to serve. With only sixty percent of mission being fulfilled for Army in 2023, and the Army Medical Department (AMEDD) being one of the most difficult to recruit for, the DHA's decision to refuse to hire specialists uniquely trained to help illnesses from which our servicemen and women often suffer seems arbitrary and inexplicable.

ABMS's actions shut out a whole range of non-member groups which provide certification services that meet or exceed ABMS's standards. These groups include but are not limited to: The American Board of Physician Specialties, a nationally recognized multi-specialty certifying organization with innovative boards that meet the needs of 21st century medicine, the American Board of Podiatric Medicine, an area of care on which amputee veterans greatly rely, the American Board of Cosmetic Surgeons, a much needed board in a rapidly growing area in urgent need of oversight, particularly because there are no residencies in cosmetic surgery, and the American

Board of Oral Maxillofacial Surgery. But for the ABMS's anticompetitive behavior, these and similar certification groups would provide physicians and hospitals with more choice and competition for certification programs.

As the Supreme Court reiterated in *North Carolina Dental*, claims of public welfare or expertise to justify state board or licensure decisions that restrict services, inhibit consumer choice, diminish innovation, or raise prices receive exacting scrutiny. ABMS's actions, if made with inadequate direct government oversight, constitute a violation of the Sherman Act because they unduly restrain the supply of medical services without a sufficient countervailing justification. This paper shows that the ABMS's abusive and anticompetitive conduct raises important antitrust concerns that legislators, courts and regulators must address.

II. About the ABMS

Like many certifying organizations, ABMS started with noble intentions, but as it has grown and become more powerful, it has placed its own financial interests over simply ensuring quality healthcare. When founded, ABMS had one job: to certify a handful of specialty medical boards. Their number has grown over the last century, and they now include twenty-four member boards and over eighty sub-specialty boards. But, once the majority of physicians became members and used to its requirements, ABMS became a gatekeeper at the major pressure points of the healthcare industry. ABMS now uses that unique position to extract fees and payments from the beginning of a physician's career via its work with the ACGME to accredit residency programs to the very end of a physician's career with his or her last maintenance of certification training.

A. The ABMS's Inflationary Effect on Medical Costs

ABMS extracts huge amounts of money from patients, physicians, and the Medicare system in the form of certification and training frees. ABMS, a nonprofit entity, and its largest ten boards

boast assets, including real estate, totaling an astounding $964,974,800 in 2016,[18] and the wealth is not simply institutional. ABMS and its largest ten member boards report CEO compensation totaling $11,144,500 million in 2016.[19] Similarly, ABMS's and its largest ten member boards have executive compensation totaling $42,757,100.[20]

The skyrocketing costs of their maintenance of certification funds this lavish organization that maintains nonprofit status. In 2000, the ABMS MOC for general medicine cost was $795, but in 2014 this cost increased to $1,940—a whopping 244% increase. The story is the same in the subspecialties, with the cost of subspecialty re-certification increasing by 257% over the same time period.[21]

Despite these extraordinary financial resources, ABMS fails in its central mission to provide better, more accessible, and more efficient healthcare for Americans. Instead, "after nearly 30 years of attempting to legitimize the existence of time limited certification, no credible data exist that the ABMS MOC program has led to improved patient outcomes."[22] In fact, "the data is ambiguous at best."[23] Recent studies see no correlation between certification and patient outcomes.[24]

Instead of developing programs with demonstrated effectiveness, ABMS has developed policies to entrench its dominance and has also worked with other organizations, such as the ACGME, and certain government entities as discussed below—including the United States Military, to restrain competition in certification, thereby imposing extraordinary costs under the

[18] *ABMS and 24 Boards, available at* WIKIMOC, http://www.wikimoc.org/2016/abms/report/pdf/color.pdf.
[19] *Id.*
[20] *Id.*
[21] Fisher & Schloss, *supra* note 13, at 41-43.
[22] *Id.*
[23] Paul S. Teirstein, *Boarded to death - Why maintenance of certification is bad for doctors and patients*, 372 NEW ENGLAND JOURNAL OF MEDICINE 106, 106 (2015).
[24] J. Hayes et al., *Association between position time-unlimited versus time-limited internal medicine board certification and ambulatory patient care quality*, 312 JAMA 2358-9 (2014).

healthcare system. Rather than welcoming new competition from rival boards, which would likely provide fresh approaches to the challenges of medical certification, ABMS has worked on numerous fronts, bobbing and weaving through the complexities of healthcare regulation, to stifle the competition. As analyzed below, the ABMS has prevented other independent and respected organizations from competing by baselessly claiming it is the only legitimate certification authority, and it thereby has reduced the available supply of physicians and forced consumers to pay more for less. Perhaps even worse, hospitals' ABMS certification requirements prevented adequate medical response during the COVID epidemic.This has all lead to the same effect: limit competition in physician board certification, increase healthcare costs, and maximize ABMS revenue. And, perhaps most tragically for American doctors and patient, diminish innovation and new approaches to certification that would lead to better healthcare.

B. The ABMS: The History and Market Structure of Medical Specialty Certification

The first few decades of the 20th century saw the emergence of medical specialty certifying boards, such as the American Board for Ophthalmic Examinations and the American Board of Otolaryngology. These boards had numerous stated purposes related to improving and maintaining levels of professional care, including to define clinical practice standards; educate the public; protect against unqualified practitioners; specify requirements for training in specialty medicine; develop educational resources for the preparation of specialists; and provide control over the examination processes for granting of specialty certification.[25]

The rapid growth of these specialty certifying boards led numerous medical organizations, including the American Medical Association, the Association of American Hospitals, the Association of American Medical Colleges, and the Federation of State Medical Boards of the

[25] Todd Sagin, "The Short Guide to Specialty Certification of Physicians," at 3, *available at* https://www.aapsfoundation.org/pdf/monograph-rev-9.pdf.

United States, to create the Advisory Board for Medical Specialties (ABMS) in 1933. This entity's purpose was to receive applications for new medical specialty certifying boards and make recommendations for their recognition. In 1948, shortly after the time of the ABMS's founding, there were eighteen (18) specialty boards.[26]

The Advisory Board for Medical Specialties eventually evolved into the modern ABMS, renamed the American Board of Medical Specialties in 1970.[27] Its focus also expanded, as medicine became more specialized and complex. At the same time, the process for a physician to become certified became more elaborate and expensive. Today the average cost is $1,863, and $2,104 for the subspecialty certifications, if necessary. Some boards such as the American Board of Allergy and Immunology and American Board of Otolaryngology imposed costs over $3,500.[28]

In addition, in the 1970s and 1980s specialty boards, starting with the American Board of Family Practice (ABFP), began to provide time-limited board certifications rather than lifetime certifications. These time-limited certifications required additional exams or study for recertification that enabled a certifying body to credibly validate the expertise of the physician they certified. However, over the last decade or so, ABMS and its member boards have transformed a needed recertification into a continuous, highly burdensome and highly expensive process. Known as maintenance of certification (MOC), this process has become a major part of the expense of medicine as virtually every ABMS specialty board now requires them.[29] Until 2017, Medicare reimbursed some of these expenses, effectively shifting this expanding maintenance cost of

[26] *Id.* at 3-4.
[27] Stephen Miller, *ABMS's Maintenance of Certification(TM): The Challenge of Continuing Competence*, 449 ORTHOPEDIC PRACTICE 155 (2006).
[28] Brian Drolet & Vickram Tandon, *Fees for Certification and Finances of Medical Specialty Boards*, 318 J. AM. MED. ASS'N 2045 (2017).
[29] Paul Kempen, *Maintenance of Certification – important and to whom?*, 3. J. COMMUNITY HOSP. INTERN MED PERSPECTIVES 1 (2013).

certification to the taxpayers.[30]

Monopolistic board certification does not only burden medical professionals, but it also harms the quality of medical care for patients. While hard data is not available, most experts believe "a majority of the nation's thousands of hospitals require an initial applicant for staff membership and/or privileges to be board certified in at least one specialty area or to be in the process of becoming board certified."[31] Many point to political and other types of influence by ABMS as a factor in the proliferation of these privilege requirements.[32] Further, the largest medical providers, such as the Department of Veteran Affairs, often discriminate against non-ABMS-certified physicians,[33] and, as discussed *infra,* the Defense Health Agency simply does not recognize non-ABMS-certified physicians. Similarly, the entities that verify board certification often refuse to include non-ABMS certified physicians. This small ministerial act creates great practical difficulties for non-ABMS physicians when trying to demonstrate their certifications to obtain employment and/or hospital privileges and in many other circumstances.

Finally, the Accreditation Council for Graduate Medical Education (ACGME) *only* accredits residency programs that lead to an ABMS-approved board certification and further requires that only ABMS certified physicians may direct and instruct these residency programs. The ACGME was founded *by the ABMS,* which also *appoints its leadership,* along with a few other groups. These interlocking nexuses of control allow ABMS to direct medical certification towards its own programs and its own profit to the detriment of competition.[34] It has been often reported that first year ACGME residents are pushed into ABMS qualifying exams – creating a

[30] Paul S Teirstein & Eric J Topol, *The role of maintenance of certification programs in governance and professionalism*, 313 JAMA 1809-10 (2015).
[31] Sagin, *supra* note 21, at 7.
[32] *Id.*
[33] Testimony Jeff L. Morris, J.D., Director of Communications & External Affairs American Board of Physician Specialties.
[34] Accreditation Council For Graduate Medical Education, Bylaws, Article IV (effective September 29, 2018), *available at* https://www.acgme.org/Portals/0/PDFs/ab_ACGMEbylaws.pdf.

direct monopolistic pipeline into ABMS board certification upon residency completion.

Most importantly, ABMS faces very little competition in its position. Today, more than 900,000 specialty physicians are board certified in one or more of the 40 specialties and 87 subspecialties approved by ABMS.[35] Its only one real competitor: the American Board of Physician Specialties (ABPS), has 12 member boards, representing 18 distinct medical specialties and has approximately 5,000 participating physicians.[36] This organization founded in the late 1950's, though relatively small, has a long, distinguished history that is well-established within the medical community and has always been a non-discriminatory volunteer-based organization.

C. Maintenance of Certification Reimbursement Programs

Another egregious example of ABMS abuse of its market position is the costly maintenance of certification (MOC) process. Virtually all of ABMS's member boards require MOCs which, as discussed above, is burdensome. The MOC process is highly profitable for ABMS and contributes to wasteful healthcare spending and the regulatory capture of medicine. ABMS uses the various MOC programs to ensure it enjoys significant financial gain from its monopolistic control of the physician certification process. Yet, the MOC remains a highly disputed program that wastefully taxes the resources of American physicians and government budgets.

While MOCs are ostensibly voluntary, they are a *de facto* requirement to have broad access to the healthcare market due to ABMS's relationships with insurance companies, hospitals, and state medical boards. As discussed below, ABMS has used a variety of techniques to make themselves the only acceptable board certification that insurance companies will recognize for

[35] American Board of Medical Specialties, ABMS Board Certification Report 2018–2019.
[36] About the American Board of Physician Specialties, Am. Bd. of Physician Specialties, *available at* https://www.abpsus.org/about-abps.

reimbursement and that hospitals will recognize for granting hospital privileges.

For example, the Centers for Medicare & Medicaid Services helps ABMS keep its position as the dominant provider. ABMS brags, that "the Centers for Medicare & Medicaid Services uses ABMS certification data for its popular 'Physician Compare' website and to determine specialties for residencies."[37] Another example, Sections 3002 and 10327 of the Patient Protection and Affordable Care Act amended Section 1848 of the Social Security Act to specifically required the maintenance of certification as necessary for this extra reimbursement and defines Maintenance of Certification Programs as "a continuous assessment program, such as qualified American Board of Medical Specialties Maintenance of Certification program or an equivalent program (as determined by the Secretary)."[38] In 2012, the ABMS's collaboration with Medicare & Medicaid Service pursuant to authority granted to HHS under Section 1848, resulted in a 0.5% bonus payment incentive from Medicare Part B dollars. The Affordable Care Act incentive was offered to all ABMS physicians that participated in the ABMS MOC up until 2017. Importantly, the Medicare & Medicaid Service did not permit non-ABMS physicians the bonus incentive, because it defined a "qualified registry" for a MOC as "a medical registry or a maintenance of certification program operated by a specialty body of the American Board of Medical Specialties."[39]

According to Linda Gorman, who directs the Health Care Policy Center at the Independence Institute, ABMS is estimated to have created a revenue stream of $1 billion dollars in 2014.[40] In 2016, the HHS FY2016 Budget in Brief reported the expenditure of a $171 billion gross fee for

[37] Press Release, ABMS Releases 2018-2019 Board Certification Report, Am. Bd. Med. Specialties (Nov. 4, 2019), *available* https://www.abms.org/news-events/abms-releases-2018-2019-board-certification-report/.
[38] 42 U.S.C. § 1395w-4.
[39] 42 C.F.R. § 414.90(b).
[40] Linda Gorman, *It's time to scrap federal physician quality measurements*, THE HILL ((Jan. 17, 2018), *available at* https://thehill.com/opinion/healthcare/369165-its-time-to-scrap-federal-physician-quality-measurements.

Medicare Part B.[41] If physician fees represent the fastest growing spending item in the Medicare budget, a 0.5% MOC bonus incentive could potentially represent a wasteful and needless spend of nearly $855 million for 2016 alone.

The ABMS's collaboration with Medicare & Medicaid Service has entrenched the certification entity that qualifies a practitioner for Medicare reimbursements. But what is worse, this is a monopoly for which the taxpayer picks up the bill, and it additionally taps into States' Medicaid & Medicare dollars. As discussed below, it is a monopoly that ABMS preserves, protects, and expands by working with other entities in a variety of different contexts.

D. The ABMS's Relationship with Insurance Companies, Hospitals, Residency Programs, and the Military

Most ordinary consumers have little understanding of what "board certification" means, nor do they particularly care about it when choosing a doctor. In this market characterized by imperfect knowledge, ABMS has the ability to use its dominance in certification to leverage its positions with other entities in the healthcare marketplace.

1. Insurance Coverage and Hospital Privileges

The relationship between ABMS and insurance companies raises serious concerns. Through its role on insurance accrediting committees, ABMS influences insurance companies to implement policies that only permit insurance reimbursement for ABMS-certified physicians. As many insurance companies have a de facto monopoly within their geographic area of service, these insurance provisions essentially grant ABMS certification monopolies over entire states.

A particularly egregious example is the Blue Cross Blue Shield of Michigan. This company holds a dominant position in the provision of health insurance in the State of Michigan with a 58%

[41] *2016 Budget in Brief*, DEP'T OF HEALTH & HUMAN SERV., *available at* https://www.hhs.gov/about/budget/fy2016/budget-in-brief/index.html.

market share.[42] Blue Cross Blue Shield Michigan with other payers, will only reimburse ABMS-certified physicians and, further, only if they participate in the ABMS MOC.

These burdensome and unnecessary requirements have led prominent members of the profession to publicly oppose ABMS. For instance, Dr. Meg Edison of Grand Rapids Michigan, board certified by the American Board of Pediatrics, an ABMS board, refused to submit to the ABMS MOC. She signed an open letter opposing the requirements. As a consequence, Blue Cross informed her that she had to immediately cease seeing any Blue Cross patients and her hospital privileges were questioned.[43]

In addition, hospital credentialing policies from all over the country share similar language requiring ABMS-certification. "The applicant must demonstrate successful completion of an Accreditation Council for Graduate Medical Education (ACGME) or American Osteopathic Association (AOA) approved residency or clinical fellowship. Current certification or active participation in the examination process leading to ABMS certification is required."

Medical residency is a necessary and well-known step of a physician's education. Without a residency, it is virtually impossible to gain medical recognition to advertise one's board certification—let alone practice as a doctor in most states. Unfortunately, every year, thousands of students graduate medical school but fail to "match," *i.e.*, they cannot find a residency program to accept them. In 2018, there were 38,376 applicants for 35,185 total positions.[44] This waste of the investment of both public and private resources in medical education is indefensible. Strangely,

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[42] *Market Share and Enrollment of Largest Three Insurers- Large Group Market, Timeframe: 2018*, KAISER FAMILY FDN., *available at* https://www.kff.org/other/state-indicator/market-share-and-enrollment-of-largest-three-insurers- large-group-market/.

[43] Meg Edison, BCBS of Michigan Supports ABMS Monopoly, Rejects NBPAS (Jun. 18, 2015), *available at* https://megedison.com/bcbs-of-michigan-supports-abms-monopoly-rejects-nbpas/.

[44] Alicia Gallegos, Match Day 2019: Residency spots increase, but improvements needed, MD. Edge (Mar. 15, 2019), *available at* https://www.mdedge.com/internalmedicine/article/196478/lifestyle/match-day-2019-residency- spots-increase-improvements.

despite the many "unmatched" doctors in 2018, there were 1,268 residency slots that remain unfilled.[45]

The ACGME controls the accreditation of allopathic residency programs and, in 2020, took over accreditation for osteopathy as well. This accreditation has an important implication for the healthcare industry. Medicare through funds appropriated by Congress, directly pays teaching hospitals well over $10 billion per year to cover the cost of their residency programs.[46] But Medicare only recognizes programs that ACGME recognizes, and ACGME only recognizes programs that lead to board certification by the ABMS and are directed by an ABMS-certified physician. All other certifying organization are excluded.[47] Last, ABMS member boards have been pushing "In-Training" on residency programs.[48] These, in essence, have been reported to be the written component of their board of certification, thereby driving the pipeline that all residents take the ABMS certification upon completion of the ACGME residency program.

ACGME is beholden to the ABMS due to the interlocking nature of these organizations—both on an institutional as well as personal level, which blurs any sort of independence, and raises questions related to collusion and conflicts of interest. As noted, ABMS is a founding member of the ACGME, and its bylaws require the ABMS to be among the entities that nominate ACGME's board members.[49] Obviously, ABMS plays a key role in picking the ACGME's leaders who will

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[45] Press Release, *Thousands Of Resident Physician Applicants Celebrate NRMP Match Results*, NAT'L RESIDENT MATCHING PROG. (Mar. 16, 2018), *available at* http://www.nrmp.org/press-release-thousands-resident-physician- applicants-celebrate-nrmp-match-results/.

[46] Congressional Research Service, Federal Support for Graduate Medical Education: An Overview (Updated December 27, 2018), *available at* https://fas.org/sgp/crs/misc/R44376.pdf; C. Chen et al., *Changes and Variation in Medicare Graduate Medical Education Payments*, 180 JAMA INTERN MED. 148 (2020).

[47] *Medicare Payments for Graduate Medical Education: What Every Medical Student, Resident, and Advisor Needs to Know* at 5, ASS'N AM. MED. COLL. (Apr. 2019), https://aamc-black.global.ssl.fastly.net/production/media/filer_public/64/77/6477adae-c4c6-4e0e-8c6f-adcdabf2bdec/dgme_-_medicare_gme_payments_what_you_need_to_know_-_20190430.pdf

[48] American Board of Emergency Medicine, *available at* https://www.abem.org/public/for-program-directors/in- training-examination; American Board of Family Medicine, *available at* https://www.theabfm.org/become- certified/acgme-program/in-training-examination.

[49] ACGME Bylaws, *supra* note 34, at Article V.

further ABMS interests, and it is often the same ABMS board members who cast the pivotal votes. For instance, former ABMS President and CEO Kevin B.

Weiss M.D. took his position as Senior Vice President of Institutional Accreditation for the ACGME immediately after leaving ABMS in 2012.[50] Under policies set forth by Dr. Weiss, ABMS boards are seamlessly rolled into the ACGME's accreditation programs.[51]

ABMS through its domination of certification of residency programs limits the supply of residency programs, causing this inexplicable market dysfunction—which creates shortages in doctors despite obvious need. New data published by the Association of American Medical Colleges shows that a projected shortage of between 42,600 and 121,300 physicians by the end of the next decade.[52] Indeed, the shortage is felt already in rural and other underserved areas. These areas can be so desperate for doctors that the State of Missouri recently allowed medical school graduates, who fail to match into residency programs, to work as "assistant physicians."[53]

2. American College of Surgeons restrictions on Hospital Emergency Departments

The American College of Surgeons (ACS) is a non-regulating entity that effectively regulates and controls entry for Level I, II, and III trauma centers through its "Committee on Trauma." This group describes its role as "setting standards that define the structures and processes of care."[54] As is the case with ACGME, it appears upon inspection of web materials that nearly all ACS board members are ABMS-certified and thus have arguably an incentive to restrict

[50] Press Release, Four senior vice presidents to join ACGME, Accreditation Council for Graduate Med. Ed. (Feb. 21, 2012), *available at* http://www.acgme.org/Portals/0/newsRel_2_21_12.pdf.
[51] Thomas J. Nasca, Kevin Weiss, et al., "The Next Accreditation System, The Clinical Learning Environment Reivew (CLER), and Milestones," Accreditation Council for Graduate Medical Education PowerPoint Presentation (2014).
[52] Association of American Medical Colleges, *Physician Supply and Demand A 15-Year Outlook: Key Findings* (Apr. 2019), *available at* https://www.aamc.org/system/files/2019-07/workforce_projections-15-year_outlook_- key_findings.pdf.
[53] Missouri State Medical Association, Assistant Physician Law, *available at* https://www.msma.org/assistant- physician-law.html
[54] American College of Surgeons, Trauma Center Programs, *available at* https://www.facs.org/quality-programs/trauma/tqp/center-programspet.

competition from non-0ABMS members.[55]

It is therefore not surprising that the ACS' latest updates limit (inclusive of all but the most rudimentary emergency room care) Level I, II, and III Trauma Center doctors to those who are certified by the ABMS, its Canadian equivalent, or the American Osteopathic Association. The updates explicitly state, "The American Board of Physician Specialists (ABPS) is NOT recognized by the ACS."[56] Thus, aside from osteopathic doctors, all U.S. emergency medicine physicians must be ABMS-certified, further limiting the supply of doctors in a much-needed field.

This anticompetitive constriction of physician supply is hardly an abstract concern. Americans sit for hours in understaffed hospital ERs, waiting for care, all across the country. A recent report of the American Academy of Family Physicians (AAFP) states that "it is unlikely that residency-trained EM physicians will be able to fill the workforce demand for several decades, if ever."[57] Even worse, these restrictions are rendering whole swathes of the county, particularly in rural areas and underserved populations, without any emergency care. A recent report of the American Academy of Family Physicians (AAFP) documents this shortage.

According to the report, "Most emergency medicine training programs are in urban areas and emergency medicine residency-trained or board-certified physicians are more likely to practice in urban settings (10.3 per 100,000 population) vs. large rural (5.3) or small rural (2.5) settings.9,13 However, newer data suggests that this maldistribution may extend beyond rural areas. For example, less than half of emergency physicians in the Veterans Health Administration have formal

[55] A recent review of the ACS board appears to indicate that nearly all current members are ABMS-board certified. ACS Website, https://www.facs.org/about-acs/governance/board-of-regents.
[56] American College of Surgeons, Clarification Document: Resources for Optimal Care of the Injured Patient, *available at* https: //www.facs.org/~/media/files/quality%20programs/trauma/vrc%20resources/clarification_document.ashx.
[57] Family Physicians Delivering Emergency Medical Care – Critical Challenges and Opportunities (Position Paper) at 2 *available at* https://www.aafp.org/about/policies/all/critical-challenges.html.

emergency medicine board certification."[58]

Beyond restricting supply of emergency physicians, the ACS' policies often result in wanton squandering of precious physician resources to patients' detriment. For instance, Dr. Russ Hartung, an emergency and trauma physician, provided care at Champlain Valley Physicians Hospital, a facility in rural upstate New York. He had a distinguished twenty-five-year career in emergency medicine and was a professor of medicine. He earned his undergraduate degree from Cornell University followed by Medical School at Albany School of Medicine. He was previously board certified by ABMS's board of internal medicine but later chose to be boarded in his specialty of emergency medicine by the ABPS. But, because he chose not to be ABMS certified, nor did he wish to recertify by ABMS in internal medicine, his continued employment at Champlain Valley Physicians Hospital would jeopardize the hospital's status as a Level 3 Trauma Center. Rather than harm an institution to which he devoted his professional life, Dr.
Hartung chose retirement.

The negative impact of ABMS-requirements was felt well beyond Dr. Hartung's retirement. It is important to note that the closest emergency medicine department outside the hospital at which he worked was over an hour away—often requiring a medivac. Champlain had great difficulty staffing its emergency department and the ACS monopolistic guidelines are damaging patient safety and care throughout the country, particularly in rural America. Not only did ACS guidelines prematurely end Dr. Hartung's career, but the residents of Champlain Valley have less emergency healthcare. How many other Champlain Valleys are there?

3. The Department of Defense and Board certification

Congress has always supported a competitive, patient- and doctor-centered approach to the

[58] *Id.* at 2-3.

contracting for medical services for the military. Section 7402 of Title 38 ("Veterans Administration") of the United States Code requires that all physicians, to be eligible to hold a position within the Administration, must hold a medical or osteopathy degree from an approved college or university, completed an internship satisfactory to the Secretary, and be licensed to practice in a state. There is no statutory basis for discriminating against various types of board certification at least in Veterans Administration. Rather, at the highest levels, Congress has always stressed to military officials the importance of competitive contracting practices for both goods and services, with recent executive action underscoring the importance of competitive provision of goods and services to the United States .

The Defense Health Agency (DHA), which has control of military hospitals and clinics worldwide as well as the Unified Medical Budget and the DOD health plan, TRICARE, and sets standards for the entire Military Health System. The DHA has procedures that have the effect of shutting out all medical specialty certifying bodies, except ABMS. Not only is the policy anticompetitive, but it raises antitrust concerns. "Exclusivity in military procurement contracts is not free from antitrust review, but . . . antitrust law does not touch such sovereign decisions of the government.[59]

Current DHA procurement regulations states that "[t]he DoD only recognizes certifications issued by boards that are members of the American Board of Medical Specialties (ABMS) or the AOA Bureau of Osteopathic Specialists." (Defense Health Agency, Procedures Manual, DHA-PM 6025.13, Vol. 4, Aug. 29, 2019, at 50). The reason for this exclusion is never explained. And, of course, the exclusion of physicians other than those certified by ABMS has the effect that all monopolies have on patients: it decreases availability and access to medical services as well as diminishes quality.

[59] Daniel A. Crane, *Fascism and Monopoly*, 118 MICH. L. REV. 1315, 1368 (2020).

Prior to this regulation, our military recruited non-ABMS physicians, many of whom are in practice today but perhaps not for long. Physicians are required to re-credential every two years, and some non-ABMS physicians have now chosen to separate from service rather than have to seek a special waiver, for which they are not assured they will receive, simply based on the fact that they did not choose the "right" certifying body for their specialty certification.

III. Antitrust Concerns Raised by the ABMS's dominance

ABMS's dominance does not result from the workings of a healthy marketplace, but rather it emerges from regulatory capture and third-party requirements for ABMS certification. ABMS uses its dominance to pressure other sub-markets in the larger healthcare marketplace that can help protect its market share or raise costs for its competitors. The Sherman Act prohibits acts that restrain trade or unlawfully maintain its monopoly in ways that injure consumers as well as agreements or understandings with other entities that restrain trade. ABMS's behavior both unlawfully maintains monopolies as well as its arrangements and agreements with other entities retraining competition in various aspects of the certification markets. In short, the ABMS's unilateral conduct, its relationships with third parties, along with state governments all raise unique antitrust concerns.

In 2012, the Federal Trade Commission summarized its enforcement guidelines in "Competition in the Professional Services." As it noted, "In the health care sector the Commission has a long record of challenging concerted efforts to exclude new competitors and forms of competition." The FTC explained that:

> Exclusion from professional associations or provider-sponsored health plans, and denial of accreditation or certification require careful analysis. Membership organizations perform valuable functions and cannot exist without membership rules, which can be procompetitive. But exclusion can harm competition if excluded professionals are unable to compete effectively without access to the group.[60]

[60] Federal Trade Commission, *Competition in Professional Services in the United States* at 6 (Sep. 2012), *available at*

The Antitrust Division of the Department of Justice further detailed how these principles apply to medical boards, noting that "Voluntary certification programs can provide information and thereby can serve a procompetitive function in the marketplace, especially in industries like healthcare where consumers often may have incomplete information about the quality of their providers."[61] However, as the Department also noted that "certification can become a de facto requirement for meaningful participation in certain markets, a certification requirement may create a barrier to entry. In such circumstances, certification may function more like licensing requirements—establishing who can and cannot participate in a market—rather than voluntary certification that can help patients and others distinguish on quality among a range of providers." It added that "the more certification comes to resemble licensing, the more such industry self-regulation raises similar concerns."[62] As explained above, the certification process has become de facto licensing due to the requirements and incentives imposed by hospitals, insurance companies, and Medicare and Medicaid Services.

Neither the FTC nor DOJ have yet to weigh in directly on whether ABMS's conduct is anticompetitive. But, applying the principles they expressed above, as well as longstanding Supreme Court precedent on licensing and professional boards, ABMS's behavior can be fairly categorized as anti-competitive.

There is nothing per se illegal for having monopoly power, but when it is abused through "unlawful and exclusionary practices," such power can violate the law. As detailed above, more

https://www.ftc.gov/system/files/attachments/us-submissions-oecd-2010-present-other-international-competition- fora/iberto-professional-services.pdf.

[61] Letter from Robert Potter, Chief Competition Policy & Advocacy Section, U.S. Department of Justice, to Dan K. Morhaim, M.D., Maryland House of Delegates, at 10 (Sept. 10, 2018), available at https://www.justice.gov/atr/page/file/1092791/download

[62] *Id.*

than 80% of certified physicians in the United States are board certified by an ABMS board.[63] This undoubtedly establishes that the ABMS has monopoly power over the market for board certification. They have abused this power in a number of ways.

A. The MOC requirements by anticompetitive means increase costs borne by both physicians and patients.

While a monopoly is not per se illegal, an antitrust "injury by reason of those things that make the practice unlawful" include "reduced output and higher prices."[64] MOCs impose tremendous burdens upon doctors in both fees, time spent taking and preparing for exams, which otherwise could be spent with patients, as well as opportunity costs.[6560] While the ABMS argues that the MOC creates benefits through additional training, doctors already have market incentives to continue their training and education, as it pertains to their practice rather than squeeze into one size fits all requirements. Moreover, the more burdensome requirements result is a higher cost for doctors to remain board certified. As explained further in the next section, the ABMS has the burden to show that the public interest justifications for these extra costs are not pretextual.

Regardless of any merits of ABMS's MOC programs, it is a textbook example how a monopoly reduces choice and increases prices. Given the immense unpopularity of the MOC programs among the physicians who actually practice medicine—and the doubtful value of continuous enrollment in MOC programs as opposed to more rational recertification exams—most doctors would have preferred board certification which did not require the MOC. Had the ABMS imposed these conditions before it became so entrenched, doctors would have chosen or created other boards. However, once the ABMS became dominant, physicians have no choice but

[63] https://www.abms.org/media/100051/abms_factsheet_2016.pdf.
[64] U.S. Gypsum Co. v. Indiana Gas Co., Inc., 350 F.3d 623, 626–27 (7th Cir. 2003).
[65] Brian Drolet & Vickram Tandon, *Fees for Certification and Finances of Medical Specialty Boards*, 318 J. AM. MED. ASS'N 2045 (2017).

to accept the high costs and inconvenience.

B. Strong Circumstantial Evidence Suggests the ABMS is involved in Exclusive Dealings with Hospitals, Insurance Companies, Verifiers, and the Accreditation Council to Restrict Competition

The Federal Trade Commission explains that an "exclusive dealing contract prevents a distributor from selling the products of a different manufacturer."[6661] As detailed above, the many hospitals, insurance companies, as well as the Accreditation Council for Graduate Medical Education, exclude physicians who do not have ABMS certification. While this does not seem like a typical distributor and manufacturer situation, the ABMS produces certified doctors, and hospitals, insurance companies, and residency programs then make those doctors available to the general public. By excluding other competitors in the board certification market, these entities are exclusively dealing with the ABMS.

As the United States Court of Appeals for the Eleventh Circuit recently explained in *McWane, Inc. v. F.T.C.,* that while "exclusive dealing arrangements are not per se unlawful," requirements to only use these arrangements "can run afoul of the antitrust laws when used by a dominant firm to maintain its monopoly. Of particular relevance . . . an exclusive dealing arrangement can be harmful when it allows a monopolist to maintain its monopoly power by raising its rivals' costs sufficiently to prevent them from growing into effective competitors."[67] ABMS's restrictions meet the threshold described in *McWane*. Rival boards cannot become effective competitors if their member physicians cannot get reimbursed by insurance programs or participate in residency training programs. Neither ABMS nor any of the organizations, which exclude rival boards have made any argument that the other boards offer inferior testing or training. While there

[66] Federal Trade Commission, *Exclusive Dealing or Requirements Contracts, available at* https://www.ftc.gov/tips-advice/competition-guidance/guide-antitrust-laws/dealings-supply-chain/exclusive-dealing-or

[67] McWane, Inc. v. F.T.C., 783 F.3d 814, 832 (11th Cir. 2015).

may be some marginal economies of scale in dealing with a single organization, these economies also create more barriers to entry and reduce choice.

That said, this does not mean that there are contracts or other pressure from the ABMS imposing these requirements on hospitals, insurance companies, state boards and accrediting bodies. In touting the necessity of ABMS certification, the Board claims "[m]any hospitals have *independently* made the decision to require board certification for staff privileges."[68] Thus, while it is theoretically possible that insurance companies or hospitals on their own without any input or direction from ABMS impose these certification requirements, ABMS's market power and the incentives it creates, suggest otherwise. ABMS's monopoly power gives it an extreme bargaining position over these entities, and the relationships, such as shared board members described above, make a strong circumstantial case that there have been exclusive arrangements.
Regardless, the public has no access to how these institutions make their decisions to have exclusive deals with the ABMS. If these arrangements are truly innocent, then these organizations should be far more transparent.

It cannot be said with certainty how the ACGME or any specific hospital, insurance company, or certification verification service decided to require ABMS and only ABMS certification. However, given the exclusionary and anticompetitive effect of these policies, regulators must scrutinize whether ABMS required such policies on a case-by-case basis. Additionally, legislators who help fund ACGME-associated institutions have an obligation to demand transparency to ensure that they are not protecting the ABMS monopoly.

C. State Laws Granting Exclusivity to the ABMS Violate the Antitrust Laws

Beyond arrangements with private entities, some state laws delegate the special privileges to

[68] Am. Bd. of Medical Specialties, A Trusted Credential, available at https://www.abms.org/board-certification/a- trusted-credential/ (accessed Jan. 15, 2010).

the ABMS, further entrenching their dominance. For example, California recently enacted its Business & Professions Code Section 651[69] to outlaw a physician advertising as "board certified unless [the physician] was a (1) a member of ABMS or (2) has a postgraduate training program approved by Accreditation Council (which is effectively ABMS, due to its membership requirements). Previously physicians could advertise as board certified if the California Medical Board determined the certifying board had "equivalent requirements."[70] It is important to remember that all members of the California Medical Board received their certifications from an ABMS-member organization.[71]

In addition to raising First Amendment concerns over the regulations of lawful, truthful and non-deceptive commercial speech such as physician speech, this statute raises obvious antitrust concerns as well.[72] As the FTC noted last year, "Restrictions on advertising interfere with that flow of information and raise the cost to consumers of finding the most suitable offering of a product or service."[73] The FTC has repeatedly applied these principles to licensing boards and professional associations. As the FTC noted in comments to the OECD, "the Commission has challenged private dental, medical, and other professional associations for various restrictions on the dissemination of truthful information."[74]

In *American Medical Association v. FTC,* the judiciary upheld the FTC's finding that "bans upon advertisement of individual physicians' services and alternative forms of medical care, and

[69] CAL. BUS. & PROF. CODE § 651.
[70] 106 CAL. CODE REGS. § 1363.5.
[71] A review of the California Medical Board's website appears to indicate that nearly all current members are ABMS board certified. *See* https://www.mbc.ca.gov/About_Us/Members/
[72] Generally speaking, commercial speech restrictions are only constitutional if (1) the regulation furthers a substantial governmental interest; (2) the regulation directly advances governmental interest asserted, and (3) it is not more burdensome than is necessary to serve that interest. Central Hudson Gas & Elec. Corp. v. Public Serv. Comm. of New York 447 U.S. 557, 566 (1980). Here, the Legislature did not identify any interest furthered by restricting the word "board certified" and, even if there were, completely eliminating a major certifying body is certainly not necessary.
[73] In the Matter of 1-800 CONTACTS, Inc., TRADE REG. REP. ¶ 80,586 (Nov. 7, 2018).
[74] Fed. Trade Comm, Competition in Professional Services in the United States, Submission to Ibero American Competition Forum (Sep. 2012), available at https://www.ftc.gov/policy/reports/us-submissions-oecd-2010-present/

restraints upon particular forms of advertising . . .have prevented doctors and medical organizations from disseminating information on the prices and services they offer, severely inhibiting competition among health care providers."[75] On its face by preventing doctors from letting consumers know they are board certified unless certified by the monopolistic and dominant partner prevents them from "disseminating information" on the "services they offer" and inhibits competition for healthcare.

State medical exclusionary practices are not limited to California. In another egregious example, the Interstate Medical Licensure Compact may put licensing of medical practitioners almost completely under ABMS control. The Compact's stated purpose is quite admirable—to coordinate state laws so as to create a "voluntary expedited pathway to licensure for qualified physicians who wish to practice in multiple states."[76] Currently, twenty-nine states, the District of Columbia and the Territory of Guam, entered into the compact, under licensing by 43 different Medical and Osteopathic Boards.[77] But, the Compact was developed through a close association with ABMS. As written, the compact will create a national commission that will have the authority to expedite the licensure of only ABMS physicians who are licensed to practice in the states who are part of the compact. The compact's wording defines a physician as someone who, "holds specialty certification or a time-unlimited specialty certificate recognized by the ABMS or the soon to be merged AOA."[78] The compact eliminates all competition for certification under its purview allowing for further regulatory capture and less state oversight on licensing.

D. Restrictions Delegating Regulatory Authority to the ABMS are not immune to Antitrust Scrutiny

[75] American Medical Ass'n v. FTC, 638 F. 2d 443, 449 (2d Cir. 1980), *aff'd,* 455 U.S. 676 (1982) (per curiam).
[76] Interstate Medical Licensure Compact website, *available at* https://imlcc.org.
[77] *Id.*
[78] Interstate Medical Licensure Compact website, *available at* https://www.abpsus.org/interstate-medical-licensure- compact.

In *Parker v. Brown*, the Supreme Court established the principle that when pursuing a regulatory agenda, a state makes "no contract or agreement and enter[s] into no conspiracy in restraint of trade or to establish monopoly" in violation of the antitrust laws. Rather, when pursuing a legitimate regulatory agenda, a state acts "as sovereign, impos[ing] the restraint as an act of government which the Sherman Act did not undertake to prohibit."[7974] Thus, the states enjoy what is often termed *Parker*-immunity when pursuing its regulatory, governmental objectives.

The Supreme Court significantly narrowed and clarified this immunity in cases such as *California Retail Liquor Dealers Association*[80] and *Ticor*.[81] The Supreme Court held this immunity only applied to "[a] state law or regulatory scheme . . . [if] first, the State has articulated a clear and affirmative policy to allow the anticompetitive conduct, and second, the State provides active supervision of anticompetitive conduct undertaken by private actors."[82] Finally, in the landmark decision, *North Carolina State Board of Dental Examiners v. F.T.C.,* the Court explained how the limitation on state antitrust immunity applies to certification and accreditation boards.[83] It announced the following test: "a state board on which a controlling number of decisionmakers are active market participants in the occupation the board regulates must satisfy *Midcal*'s active supervision requirement in order to invoke state-action antitrust immunity."[84]

The Federal Trade Commission has provided significant guidance as to how it will apply the *North Carolina State Board* test.[85] First, the board at issue must consist "active participants" in

[79] Parker v. Brown, 317 U.S. 341, 352 (1943).
[80] California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).
[81] F.T.C. v. Ticor Title Ins. Co., 504 U.S. 621, 631 (1992).
[82] *Id.*
[83] 574 U.S. 494 (2015).
[84] *Id.* at 511.
[85] *Staff Guidance on Active Supervision of State Regulatory Boards Controlled by Market Participants* (Oct. 2015), available at https://www.ftc.gov/system/files/attachments/competition-policy- guidance/active_supervision_of_state_boards.pdf

the market that is regulated and, second, these "active participants" constitute a "controlling number" of the board at issue. "Active participant" in the market regulated includes any member that offers any service subject to regulation by the board. A member is a participant even if a subspecialty in which she or he does not practice is an issue, i.e., orthodontists are active participants in the dentistry market. Similarly, a member is a participant even if he or she suspends or no longer practices his or her profession.[86]

Second, a controlling number of active participants does not require a majority. Active market participants may constitute a controlling number of board members if they are able to control a decision by veto power, tradition, or practice—formal voting control is not necessary. Therefore, the FTC will determine "controlling number" on individualized bases, considering many factors, including: the organizational structure of the regulatory board at issue, participation of non-market participant members, or whether active market participant members have different board authority than non-market participant members.[8782]

Finally, the FTC provided guidance on what constitutes active supervision. Under the FTC's implementation of the principles announced in *North Carolina Board of Dental Examiners,* active supervision must include, to the extent not already performed by the board, itself, collection of relevant facts and data; public hearings and studies; public comments; and review of market conditions and documentary evidence. In addition, there must be an evaluation of the substance of the recommended action and whether the action complies with state standards and, finally, issuance of a written decision approving, modifying or rejecting the proposed action, including a rationale for the decision.

The precedent in *North Carolina Board of Dental Examiners* leaves countless state laws and

[86] *Id.*
[87] *Id.*

board actions open to antitrust challenge. California's Business & Professions Code Section 651 discussed is a prime example. This provision explicitly prohibits physicians from advertising themselves as "board certified" unless certified by an ABMS board or the ACGME. Following the test in *North Carolina Board of Dental Examiners*, Section 651 thereby (i) delegates to non-sovereign entities control over who can advertise, a governmental function; (ii) the State of California has limited, in fact, has no control over how the ABMS and the Accreditation Council decide who is board certified; and, (iii) the ABMS and the Accreditation Council are market actors who are competing against other certifying boards and institutions. Similarly, Florida's Department of Health's Trauma Center Standards require "board certification" for positions such as trauma medical director, general surgeon, and pediatric surgeon. It defines "board certified" to mean ABMS or a foreign equivalent.[88]

E. ABMS's conduct is not excused under public interest

Professional associations and licensing boards are inherently exclusionary. While the public wants strong competition among qualified doctors, engineers, lawyers, and others in the "learned professions," the public also depends on these organizations to prevent unethical or unqualified members from harming consumers. Yet setting standards cannot be used as a pretext for excluding qualified professionals from competing in the market.

In 1975, *Goldfarb v. Virginia State Bar*, the Supreme Court ruled that antitrust can apply to professional organizations, reasoning that "[t]he nature of an occupation, standing alone, does not provide sanctuary from the Sherman Act . . . nor is the public -service aspect of professional practice controlling in determining whether § 1 includes professions."[89] In 1978, expanding on

[88] Florida Department of Health Pamphlet, Trauma Center Standards 150-9 (revised Jan. 2010), available at http://www.floridahealth.gov/licensing-and-regulation/trauma-system/_documents/traumacntrstandpamphlet150-9-2009rev1-14-10.pdf.
[89] 421 U.S. 773, 787 (1975).

Goldfarb, the Court in *National Society of Professional Engineers v. U. S.*, denied a public interest justification to an engineer association's canon of ethics that prohibited competitive bidding.[90] The Court rejected the claim that because the canon "was adopted by members of a learned profession for the purpose of minimizing the risk that competition would produce inferior engineering work endangering the public safety," antitrust had no application. Instead, the Court looked at the agreement and held that "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."[91]

Simply organizing as a non-profit does not change these motives. As the Supreme Court held in *California Dental Association* v. *FTC*,

> Nonprofit entities organized on behalf of for-profit members have the same capacity and derivatively, at least, the same incentives as for-profit organizations to engage in unfair methods of competition or unfair and deceptive acts. It may even be possible that a nonprofit entity up to no good would have certain advantages; it would enjoy the screen of superficial disinterest while devoting itself to serving the interests of its members without concern for doing more than breaking even.[92]

In *Wilk v. American Medical Association*, the Seventh Circuit held that a public interest justification for a restriction on entry only applies if a group or association had "genuinely entertained a [public interest] concern. ..... (2) that this concern is objectively reasonable; (3) that this concern has been the dominant motivating factor in defendants' ..... conduct intended to implement it; and (4) that this concern .....could not have been adequately satisfied in a manner less restrictive of competition."[93]

Perhaps having learned from their past antitrust violations, in 2014 the American Medical Association laid out a number of principles of how MOCs could be reasonably enacted, which are in line with the rules established by the courts.[94] These principles include:

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[90] 435 U.S. 679, 679 (1978).
[91] *Id.* at 692.
[92] 526 U.S. 756, 768 (1999).
[93] Wilk v. Am. Med. Ass'n, 719 F.2d 207, 227 (7th Cir.), adhered to, 735 F.2d 217 (7th Cir. 1983).
[94] American Medical Association, *AMA adopts principles for maintenance of certification*, (Nov. 10, 2014),

- The "MOC should be based on evidence and designed to identify performance gaps and unmet needs, providing direction and guidance for improvement in physician performance and delivery of care."
- "The MOC program should not be a mandated requirement for licensure, credentialing, payment, network participation or employment."[95]

Given the breadth of the restrictions and ABMS's financial interest maintaining its monopoly, it is hard to accept that its public interest justifications for raising prices and excluding competitors is "genuine," much less the "dominant motivating factor" in excluding competitors. Even if it were, there are undoubtedly other ways to achieve and identify performance gaps and improve physician performance than creating continuous de facto mandatory testing regimes.

Perhaps most fundamentally, while board certification and MOCs no doubt help to identify performance gaps and even improve physician performance, there is nothing intrinsic to the ABMS that makes it the only organization that can provide such services. The ACGME, hospitals, or insurance companies can set reasonable, objective, and non-pretextual standards for all boards to meet, which would address whatever public interest concerns they have, rather than simply delegate this authority to the ABMS.

IV. Conclusion

In his 1901 novel, *The Octopus: A Story of California*, Frank Norris powerfully relates how the railroad monopoly came to control every aspect of farmers' livelihoods, ranging from freight rates to land prices. Similarly, the ABMS has grown tentacles that reach into every aspect of a physicians' livelihood—from residency, to hiring practices, to insurance reimbursement, access to advertising and rights to commercial free speech, hospital privileges, and the ability to work with Medicaid and Medicare patients. These restrictions on doctors ultimately harm patients, who face

available at https://www.ama-assn.org/education/cme/ama-adopts-principles-maintenance-certification.
[95] *Id.*

higher prices and more restricted choices.

Legislators, regulators, and prosecutors can help increase competition in the healthcare industry by taking concrete steps to break the ABMS's monopolistic hold. Just as doctors must follow the Hippocratic maxim *primum non nocere (*first do not harm)—states must repeal any law, regulation, or policy that designates the ABMS as the sole recognized physician certifying body. The safety and quality requirements that states want can be achieved with objective criteria rather than designating an unaccountable monopoly. Next, whether through legislation or antitrust enforcement the exclusive dealings from the ACGME, insurance companies, hospitals, and verifiers should be scrutinized. These entities, in applying fair, open, and objective criteria, could end up using a board, but restricting reliance to a single monopoly harms patients and physicians and further inflates healthcare costs.

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