U.S. Department of Justice

Antitrust Division

Liberty Square Building

450 5th Street, N.W.
Washington, DC 20001

September 10, 2018

The Honorable Dan K. Morhaim, M.D.
The Maryland House of Delegates
6 Bladen Street, Room 362
Annapolis, MD 21401

Dear Delegate Morhaim:

In response to your request dated August 17, 2018,[1] the United States Department of Justice, Antitrust Division ("Division") welcomes the opportunity to share our views on Maryland House Bill 857 (the "Bill"), currently under review by a Maryland Health Care Commission ("MHCC") workgroup. You have indicated that the focus of this review is on the use by hospitals, insurers, and others of certification programs for physicians in medical specialties and, in particular, the Maintenance of Certification ("MOC") program as currently implemented by the American Board of Medical Specialties ("ABMS") and its member boards. We applaud the legislature for putting a spotlight on the potential impact of specialty board certification on competition in markets for physician services.

As described in your letter, you seek our views in two areas. First, you ask whether ABMS "may harm competition by imposing overly burdensome conditions on physicians who wish to maintain their certification."[2] According to your letter, ABMS, a private organization governed by market participants, has a monopoly in the certification of physicians in Maryland, and board certification functions as a de facto requirement for practice by physicians in

[1] Letter from Dan K. Morhaim, Delegate, Maryland House of Delegates, to Matthew Mandelberg, Antitrust Div., U.S. Dep't of Justice, & Daniel J. Gilman, Fed. Trade Comm'n (Aug. 17, 2018) [hereinafter *Letter*].

[2] *Id.* at 2.

certain specialized fields.[3] When such circumstances exist, certifying bodies may have incentives to adopt certification requirements more stringent than those necessary to verify that providers have the knowledge and skills required of specialty practice and the ability to deliver quality care. Unnecessary requirements can raise the costs of specialty practice and constrain the supply of specialized practitioners, thereby harming competition and increasing the cost of healthcare services to consumers.

Second, you present policy options available to the Maryland legislature if the legislature concludes that ABMS's MOC program harms healthcare competition in Maryland. Your letter indicates that Maryland broadly is considering one of three possible approaches:

(1) "[D]o nothing and wait for the market to self-correct,"
(2) "[P]ass a law under which hospitals may not require physicians to maintain board certification," or
(3) Promote "competition between legitimate certifying bodies"—for example, "by recognizing a competitor to ABMS—the National Board of Physicians and Surgeons (NBPAS)—as a legitimate accrediting organization, potentially among others."[4]

The Division recognizes the critical importance of patient health and safety and the role of state legislators and regulators in determining the optimal balance of policy priorities as they regulate the provision of healthcare services. We welcome the opportunity to share our views on these policy choices before the legislature to help facilitate the benefits of competition for Maryland's healthcare consumers.

The Division encourages the Maryland legislature to consider ways to facilitate competition by legitimate certifying bodies, consistent with patient health and safety. Physicians, hospitals, healthcare consumers, insurers, and others can benefit from competition to provide cost-effective, high-quality certification services. Toward that end, the Division encourages drafters of the Bill to consider ways to allow for entry by additional, legitimate certifying bodies.

At the same time, the Division encourages the Maryland legislature to continue allowing hospitals and insurers independently to decide whether to

[3] The Division has not independently evaluated the factual representations contained in your letter.

[4] *Letter*, *supra* note 1, at 2-3.

consider a physician's MOC status when making business decisions, such as granting hospital privileges. The Division is concerned that the second approach outlined above could unnecessarily interfere with hospitals' and others' unilateral business decisions and thereby harm, not improve, the competitive landscape of healthcare in Maryland. If hospitals and insurers are free to decide whether Maintenance of Certification or another recertification program is a useful tool to identify skilled and qualified physicians, then use of such programs can promote competition and provide benefits for patients. To avoid unnecessary, unintended, or overbroad restrictions on competition, the Division recommends that the legislature not restrict such competitive benefits unless a restriction is determined to be necessary and narrowly tailored to redress well-founded consumer harms or risks.

I. Background

a. The Division's Interest and Experience in Healthcare Competition

Competition is a core organizing principle of the American economy,[5] and vigorous competition among sellers in an open marketplace gives consumers the benefits of lower prices, higher quality goods and services, increased access to goods and services, and greater innovation.[6] The Division works to promote competition through enforcement of the antitrust laws, which prohibit certain transactions and business practices that harm competition and consumers, and through competition advocacy efforts, which urge federal and state governmental bodies to make decisions that benefit competition and consumers—via comments on legislation, discussions with regulators, and court filings, among other channels.

Because healthcare competition is vitally important to the economy and consumer welfare, this sector has long been a priority for the Division.[7]

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[5] *See, e.g.*, N.C. State Bd. of Dental Exam'rs v. F.T.C., 135 S. Ct. 1101, 1109 (2015) ("Federal antitrust law is a central safeguard for the Nation's free market structures."); Standard Oil Co. v. F.T.C., 340 U.S. 231, 248 (1951) ("The heart of our national economic policy long has been faith in the value of competition.").

[6] *See, e.g.*, Nat'l Soc'y of Prof'l Eng'rs v. United States, 435 U.S. 679, 695 (1978) (noting that the antitrust laws reflect "a legislative judgment that ultimately competition will produce not only lower prices, but also better goods and services. . . . The assumption that competition is the best method of allocating resources in a free market recognizes that all elements of a bargain—quality, service, safety, and durability—and not just the immediate cost, are favorably affected by the free opportunity to select among alternative offers.").

[7] An overview of the Division's healthcare-related activities is available at http://www.justice.gov/atr/health-care.

Specifically, the Division has extensive experience investigating the competitive effects of mergers and business practices of insurers, hospitals, pharmacy benefit managers, physicians, and other providers and distributors of healthcare goods and services. The Division also has provided guidance to the healthcare community on the application of the antitrust laws and sponsored various workshops and studies to examine the healthcare industry. Finally, through competition advocacy, the Division has encouraged government officials at all levels to consider the competitive impact of various healthcare-related legislative and regulatory proposals, including licensing and other restrictions that impact the practice of healthcare.[8]

b. Board Certification in the Market for Physician Services and the Maintenance of Certification Program

ABMS is the leading certifying body for medical doctors in the United States. Unlike state licensure, which sets minimum legal requirements to practice medicine generally, ABMS certification is voluntary and is designed to indicate that a physician has demonstrated proficiency in a particular specialty or subspecialty. ABMS is a federation of 24 medical specialty boards that today certify physicians in 39 specialties and 86 subspecialties.[9] To apply to one of these boards for initial certification, a physician must earn a medical degree, complete a residency program, obtain a license to practice medicine, and then pass an exam created and administered by the relevant ABMS board.[10]

Historically, physicians received lifetime certification from ABMS, but by 1990, at least eighteen ABMS member boards had revised their policies so that newly issued certificates were time-limited.[11] As of today all member boards are

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[8] *See, e.g.*, Letter from Marina Lao, Dir., Off. of Pol'y Planning, Fed. Trade Comm'n, & Robert Potter, Chief, Legal Pol'y Sec., Antitrust Div., U.S. Dep't of Justice, to Hon. Bradley H. Jones, Jr., Mass. House of Representatives (Feb. 18, 2016) (evaluating competitive considerations regarding Massachusetts legislation to lessen scope-of-practice restrictions on Massachusetts optometrists in the treatment of glaucoma), https://www.justice.gov/opa/file/826371/download; FED. TRADE COMM'N & U.S. DEP'T OF JUSTICE, IMPROVING HEALTH CARE: A DOSE OF COMPETITION, Ch. 2, 25–33 (2004), http://www.usdoj.gov/atr/public/health_care/204694.htm (considering the competitive impact of licensing restrictions in health care, including a brief discussion of the potential impact of certification).

[9] AM. BD. OF MED. SPECIALTIES, ABMS GUIDE TO MEDICAL SPECIALTIES 5 (2018), https://www.abms.org/media/176512/abms-guide-to-medical-specialties-2018.pdf.

[10] *Id.* at 9.

[11] Richard J. Glassock et al., *Time-Limited Certification and Recertification: The Program of the American Board of Internal Medicine*, 114 ANNALS INTERNAL MED. 59, 59 (1991).

required by ABMS, as part of their MOC programs, formally to test their diplomates for knowledge of core content, judgment, and skills in the specialty no less often than every 10 years, among other requirements.[12]

In recent years, ABMS member boards have further increased MOC requirements for certified specialties. In particular, the American Board of Internal Medicine ("ABIM"), which grants certificates in internal medicine and for 20 subspecialties,[13] has increased its requirements in a way that has generated much debate among doctors and the broader public.[14] ABIM is the largest ABMS member board with more than 200,000 physicians certified—approximately one in every four physicians in the United States.[15] In 1990, ABIM joined other boards in having new certificates expire every 10 years unless they are renewed following must-pass exams in a physician's specialty or subspecialty.[16] ABIM estimates that these proctored exams take a "full day of testing."[17] In 2005, ABIM-certified physicians were also required to complete medical knowledge modules and quality improvement projects to earn "MOC points" in addition to the must-pass exam every 10 years and in addition to continuing medical education ("CME") activities to fulfill state licensure requirements.[18] The number of MOC points required in a 10-year period doubled in 2014 to 200 points.[19] Those points could no longer be earned at any time across a 10-year period but rather at more regular intervals: at least some MOC points every 2

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[12] AM. BD. OF MED. SPECIALTIES, STANDARDS FOR THE ABMS PROGRAM FOR MAINTENANCE OF CERTIFICATION (MOC) 10 (approved Jan. 15, 2014), https://www.abms.org/media/1109/standards-for-the-abms-program-for-moc-final.pdf.

[13] *Mission*, AM. BD. OF INTERN. MED., https://www.abim.org/about/mission.aspx (last visited Aug. 28, 2018).

[14] *See, e.g.*, *infra* note 24 (citing critical commentary).

[15] AM. BD. OF INTERN. MED., *supra* note 13.

[16] Glassock et al., *supra* note 11, at 59.

[17] *MOC Assessments in 2018*, AM. BD. OF INTERN. MED., https://www.abim.org/maintenance-of-certification/moc-faq/moc-assessments.aspx (last visited Sept. 6, 2018).

[18] Westby G. Fisher & Edward J. Schloss, *Medical Specialty Certification in the United States-a False Idol?*, 47 J. of Interventional Cardiac Electrophysiology 37, 39 (2016).

[19] *Id.*

years and 100 points every 5 years.[20] Required fees increased as well.[21] One estimate of the overall burden of the 2015 MOC program for individual physicians in terms of fees and time costs finds an average of over $16,000 for general internists and over $40,000 for some subspecialties over a ten-year period.[22]

Physicians with unexpired certificates who do not satisfy MOC requirements are listed publicly as not participating in MOC requirements.[23] Physicians who do not maintain certification or are not recertified may risk professional consequences. Survey research suggests that more than 55 percent of hospitals require that physicians with admitting privileges fulfill board recertification requirements.[24] These hospital admitting privileges can impact physician earnings.[25] Likewise, a survey found that more than a third of health plans require surgeons and nonsurgical subspecialists with time-limited certificates to recertify in their specialty.[26]

ABIM's new MOC requirements garnered critical responses from certain prominent physician organizations, including the American Medical Association, the American College of Physicians and Surgeons, and the American Association of Clinical Endocrinologists.[27] Practicing physicians have disputed the need for

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[20] *Changes in ABIM Maintenance of Certification: What Does It Mean for You?*, NEJM KNOWLEDGE+, https://knowledgeplus.nejm.org/blog/changes-abim-maintenance-certification-mean/(Apr. 18, 2014).

[21] Sandhu et al., *A Cost Analysis of the American Board of Internal Medicine's Maintenance-of-Certification Program*, 163 ANNALS. INTERNAL MED. 401, 401 (2015).

[22] *Id.* at 404 (90% of these costs are time costs).

[23] AM. BD. OF MED. SPECIALTIES, ABMS MOC OVERVIEW AND FAQS 2 (updated Apr. 2018), https://www.abms.org/media/182755/abms-moc-overview-and-faqs-abmsorg-20180511.pdf.

[24] Gary L. Freed et al., *Use of Board Certification and Recertification in Hospital Privileging*, 144 ARCHIVES SURGERY 746, 749 (2009); *see also* Gary L. Freed et al., *Changes in Hospitals' Credentialing Requirements for Board Certification From 2005 to 2010*, 8 J. HOSP. MED. 298, 300 (2013) (finding an increasing share of hospitals require board recertification for pediatricians).

[25] *See, e.g.*, John A. Rizzo & John H. Goddeeris, *The Economic Returns to Hospital Admitting Privileges*, 23 J. HEALTH POL. POL'Y & L. 483, 502-06 (1998).

[26] Gary L. Freed et al., Health Plan Use of Board Certification and Recertification of Surgeons and Nonsurgical Subspecialists in Contracting Policies, 144 ARCHIVES SURGERY 753, 756 (2009).

[27] Cheryl Clark, *AMA Pans 'High Stakes' Exams*, MEDPAGE TODAY, June 16, 2016, https://www.medpagetoday.com/meetingcoverage/ama/58594; AM. COLL. OF PHYSICIANS & SURGEONS, POSITION STATEMENT ON REGULATION OF CREDENTIALING AND LICENSING (approved

the increasingly stringent MOC requirements,[28] and critics have pointed to literature suggesting MOC's purported benefits are unsupported by evidence.[29] Opponents also highlight the costs of MOC in terms of physician time and money,[30] and some have expressed concerns about MOC's potential impact on certain physician career paths,[31] thus potentially restricting the supply of specialized medical services. ABIM contests these arguments and claims the benefits of MOC requirements have support in the literature.[32]

June 1, 2017), https://www.acponline.org/acp_policy/policies/state_regulation_of_credentialing_2017.pdf; AM. ASS'N OF CLINICAL ENDOCRINOLOGISTS, AACE POSITION STATEMENT ON LIFELONG LEARNING (adopted May 12/13, 2014), https://www.aace.com/files/position-statements/lifelong-learning-moc.pdf.

[28] *See*, e.g., Andrew J. Schuman, *MOC: A View from the Trenches*, Contemporary Pediatrics, Apr. 1, 2017, http://www.contemporarypediatrics.com/contemporary-pediatrics/news/moc-view-trenches ("I honestly have not encountered a pediatrician in clinical practice who has anything good to say about the [MOC] program"); David A. Cook et al., *Getting Maintenance of Certification to Work: A Grounded Theory Study of Physicians' Perception*, 175 JAMA INTERN. MED. 35, 41 (2015) (concluding from eleven focus groups that "Physicians view MOC as an unnecessarily complex process that is misaligned with its purposes"); Paul S. Teirstein, Perspective, *Boarded to Death – Why Maintenance of Certification is Bad for Doctors and Patients,* 372 NEW ENG. J. MED. 106, 107 (2015), https://www.nejm.org/doi/full/10.1056/NEJMp1407422 (describing the author's anti-MOC petitions in the context of physician surveys finding broad opposition to MOC).

[29] *See*, e.g., Paul S. Tierstein & Eric J. Topol, Viewpoint, *The Role of Maintenance of Certification Programs in Governance and Professionalism*, 313 J. AM. MED. ASS'N 1809, 1809 (2015) (questioning whether MOC is "evidence based" given the tepid results of ABMS funded research); John H. Hayes et al., *Association Between Physician Time-Unlimited vs Time-Limited Internal Medicine Board Certification and Ambulatory Patient Care Quality*, 312 JAMA INTERN. MED. 2358, 2358 (2014) ("no differences in outcomes for patients cared for by internists with time-limited or time-unlimited certification for any performance measure").

[30] *See, e.g.*, Alexander T. Sandhu et al, *A Cost Analysis of the American Board of Internal Medicine's Maintenance-of-Certification Program*, 163 ANNALS INTERNAL MED. 401, 407 (2015), http://annals.org/aim/article-abstract/2398911/cost-analysis-american-board-internal-medicine-s-maintenance-certification-program.

[31] *See, e.g.*, PHYSICIAN-SCIENTIST WORKFORCE WORKING GRP., NAT'L INST. OF HEALTH, *Challenges Facing the Physician-Scientist Workforce*, in PHYSICIAN-SCIENTIST WORKFORCE REPORT 2014 (2014), https://report.nih.gov/workforce/psw/challenges.aspx.

[32] *See, e.g.*, Eric S. Holmboe et al. *Association Between Maintenance of Certification Examination Scores and Quality of Care For Medicare Beneficiaries*, 168 ARCH. INTERN. MED. 1396, 1396 (2008) (Physician cognitive skills measured by MOC are associated with higher rates of processes of care for Medicare patients); Bradley M. Gray et al., *Association Between Imposition of a Maintenance of Certification Requirement and Ambulatory Care-Sensitive Hospitalizations and Health Care Costs*, 312 JAMA INTERN. MED. 2348, 2348 (2014) ("Imposition of the MOC requirement… associated with a small reduction in the growth differences of costs for a cohort of Medicare beneficiaries"); David G. Nichols, *Maintenance of Certification and the Challenge of Professionalism*, 139 PEDIATRICS, May

ABIM's MOC requirements have continued to evolve in recent years in the wake of this feedback. For example, MOC points now can be earned from CME activities. Beginning in 2018, an ABIM-certified physician has the option to take shorter MOC assessments with greater frequency in the form of "Knowledge Check-Ins," in lieu of a long-form exam.[33] These Knowledge Check-Ins may take 3 hours every two years, instead of a full-day exam every ten years.[34] Physicians can fail a Knowledge Check-In, so long as they do not fail on consecutive tests, whereas physicians will lose certification after failing the full-day exam once. ABIM is also revising these assessments to be open book.[35]

c. Board Certification under Maryland State Law

Although certification by ABMS or a member board is technically voluntary, Maryland state law does require board certification for various state law purposes. For example, a physician is only permitted to advertise oneself as board-certified as that term is defined under state law.[36] Maryland defines "board certification" in these contexts to include only certification by certain named boards.[37] ABMS is the primary U.S. body permitted to provide medical doctors with board certification as defined by state law. The state code also

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2017, at 1, 10 ("MOC is associated with better care or has been an incentive for physicians to collaborate in systematically improving patient care and outcomes"); David W. Price et al., *Can Maintenance of Certification Work? Associations of MOC and Improvements in Physicians' Knowledge and Practice*, ACAD. MED. (forthcoming) (manuscript at 11), https://www.ncbi.nlm.nih.gov/pubmed/29952770 (Out of 39 studies, 37 reported that MOC was associated with at least one positive outcome).

[33] Richard J. Baron *ABIM Increases Physician Choice with New Assessment Option,* ABIM BLOG (Dec. 14, 2016), http://blog.abim.org/abim-increases-physician-choice-with-new-assessment-option.

[34] *MOC Assessments in 2018*, AM. BD. OF INTERNAL MED., https://www.abim.org/maintenance-of-certification/moc-faq/moc-assessments.aspx#difference (last visited Sept. 7, 2018).

[35] Richard J. Baron, *Spring 2017 update: Tentative timeline for open-book and options you requested,* ABIM BLOG (Mar. 29, 2017), http://transforming.abim.org/spring-2017-update-tentative-timeline-for-open-book-and-options-you-requested.

[36] MD. CODE ANN., HEALTH OCC. § 14-503(a)(1) (West 2017). *See also* MD. CODE ANN., HEALTH OCC. § 14-401.1(e)(2)(i) (West 2017) (state-approved board certification required for physician peer reviewers in disciplinary actions); MD. CODE ANN., HEALTH INS. § 15-10B-09.1(1) (West 2017) (grievance procedure decisions must involve board-certified physician); MD. CODE ANN., HEALTH INS. § 15-123(f) (West 2017) (Maryland insurers must use board-certified physicians to evaluate reimbursement claims for emerging treatments).

[37] MD. CODE ANN., HEALTH OCC. § 14-101(c)(1) (West 2017).

permits certification by the American Osteopathic Association, the Royal College of Physicians and Surgeons of Canada, and the College of Family Physicians of Canada.[38]

II. Maryland House Bill 857

In the wake of public criticism of ABMS and its MOC requirements, Maryland House Bill 857 was introduced in the Maryland legislature on February 2, 2018.[39] On March 13, 2018, the Maryland House Health and Government Operations Committee asked the Maryland Health Care Commission (MHCC) to lead a study effort with relevant stakeholders to evaluate problems with the existing maintenance of certification requirements for physicians.[40] The goal of the study effort is to make recommendations for the 2019 legislative session.

The MHCC subsequently formed the Maintenance of Certification Workgroup (the "Workgroup"), which has its fourth and final meeting on September 11, 2018. The Workgroup's final product will be a report with recommendations delivered to the MHCC Commissioners, followed by a final report submitted to the Health and Government Operations Committee.[41] The Workgroup's latest public draft of the Bill includes the following provisions:

- adding the National Board of Physicians and Surgeons (NBPAS) to the list of approved certifying bodies for physicians for various state-law purposes,
- redefining board certification under state law so that physicians still qualify as board certified for various state-law purposes if they lack certification only because they did not participate in MOCs, and

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[38] *Id.*

[39] *HB0857 History*, GEN. ASSEMB. OF MD. (Mar. 15, 2018), http://mgaleg.maryland.gov/webmga/frmMain.aspx?pid=billpage&stab=03&id=hb0857&tab=subject3&ys=2018RS.

[40] Letter from Shane E. Pendergrass, Chairman, House Health and Gov't Operations Comm., Md. House of Delegates, to Ben Steffer, Exec. Dir., Md. Health Care Comm'n (Mar. 12, 2018), https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/moc/Physicians_Specialty_Certifications_Study_HB%20857_Request_HGO.pdf.

[41] Maint. of Certification Workgroup, Maryland Health Care Comm'n, Physician Maintenance of Certification Work Group 2 (Jul. 24, 2018) (presentation slides) ("Work Plan Reminder"), https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/moc/7_24_2018_MOC_Wrkgrp_Prst_v2.pdf.

- prohibiting carriers and hospitals from requiring MOCs or another continuous certification program of physicians as prerequisite to, or for the continuation of, the approval of a credential, reimbursement, employment, hospital admitting privileges, or the provision of malpractice coverage.[42]

III. Analysis

a. Competition and Certification

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. In particular, certification can signal that a practitioner has the distinct skills, knowledge, and abilities to practice a specialty that go beyond licensing requirements, if any, in a particular field. That signal can promote specialization, choice, and competition. For example, a consumer with specialized needs can more efficiently search for providers who have signaled expertise in the relevant specialty. In turn, a provider may attract more consumers or charge a premium reflecting the value of the specialized service, and that premium may encourage other providers to pursue that specialty and offer services in that narrower market. Certifications can also signal enhanced quality, perhaps by certifying that a provider has demonstrated a certain level of training, testing, or experience over and above other providers. That signal can help consumers distinguish among providers for the same service based on the quality of service they expect to receive. This ability to distinguish may provide higher quality providers an incentive to invest in higher quality care.

Private certifying bodies, however, can raise competition concerns under certain circumstances. Certifying bodies are frequently governed by active market participants.[43] Because, like other forms of professional standards-setting, certification can become a de facto requirement for meaningful

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[42] Maint. of Certification Workgroup, Md. Health Care Comm'n, HB 857 Amendments version 2 (Jul. 24, 2018), https://mhcc.maryland.gov/mhcc/pages/home/workgroups/documents/moc/HB%20857%20West%20amendment.pdf.

[43] *See, e.g.*, *ABMS Board of Directors*, AM. BD. OF MED. SPECIALTIES (last visited Aug. 29, 2018), https://www.abms.org/about-abms/governance/abms-board-of-directors/(vast majority of boardmembers are medical doctors); *Board of Directors*, AM. BD. OF INTERNAL MED., https://www.abim.org/about/governance/board-of-directors.aspx (last visited Aug. 29, 2018) (same).

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.

The more certification comes to resemble licensing, the more such industry self-regulation raises similar concerns. For example, as the U.S. Supreme Court has explained, though market participants offer important and needed experience and expertise about their practice and profession,[44] such professionals, when empowered to set licensing requirements without meaningful review, "may blend [ethical motives] with private anticompetitive motives in a way difficult even for market participants to discern."[45] Similarly, competitive concerns can arise when private standard-setting processes become "biased by members with economic interests in restraining competition."[46] The governing members of a dominant certifying body may have incentives to set certification requirements more stringently than is necessary to certify that providers have the relevant knowledge and skills. In situations where one certifying body has become dominant, such that physicians cannot turn to alternative bodies for a similar certifying function, market forces might not constrain the dominant body from acting on these incentives. If requirements artificially constrain the supply of certified providers and raise their costs, certification may limit competition among providers and allow for providers to raise prices paid by payers and consumers. As this letter discusses further below, if competition among bona fide certifying bodies were to develop, that could provide a meaningful check on such incentives. Moreover, even where there is no effective competition among certifying bodies, incentives to raise barriers for physicians to practice medical specialties by setting unnecessarily stringent certification requirements could be circumscribed to the extent a certifying body has procedures in place to ensure that input is available from, and decision-making is vested in, groups that represent a balance among the

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[44] *See* N. Carolina State Bd. of Dental Examiners v. F.T.C., 135 S. Ct. 1101, 1115 (2015) ("State laws and institutions are sustained by this tradition when they draw upon the expertise and commitment of professionals.").

[45] *Id.* at 1111.

[46] Allied Tube & Conduit Corp. v. Indian Head, Inc., 486 U.S. 492, 509 (1988).

various relevant stakeholders, including not only doctors, but also, potentially, hospitals, insurers, and patient advocacy groups.[47]

For these reasons, there would be competition concerns if dominant certifying bodies set de facto participation requirements that did not sufficiently correspond to health, safety, or other procompetitive justifications. Certifying bodies should use objective standards and not misapply those standards to disadvantage competition.[48] To protect against the risks of straying from appropriate standards, the Division encourages such private bodies to make decisions through processes that represent a balanced group of stakeholders. The Division also encourages states to adopt policies that do not foreclose entry by bona fide certifying bodies that may serve as a competitive alternative to existing certifying bodies.

b. Competition and the Proposed Legislation

The Workgroup's Bill adds NBPAS to the list of entities whose certifications would make physicians "board certified," as that term is defined in Maryland state law. In doing so, the bill could allow for a competitive alternative to ABMS in certifying medical specialists for the various purposes proscribed by the state law definition.[49] Moreover, to the extent that such a state-law imprimatur has a reputational effect in markets for physician services outside of these state law purposes, expanding the list of state-approved certifying bodies could facilitate entry of rival certification bodies more broadly. Without speaking to the merits of any particular certifying body or its requirements, the Division believes that more entry and more competition by bona fide certifying bodies may offer important benefits—including lowering the costs for physicians to be certified or improving the quality of certification services—for healthcare providers, consumers, and payers that the Maryland

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[47] *Cf.* Allied Tube, 486 U.S. at 501 (noting that "private standards can have significant procompetitive advantages" if "procedures [] prevent the standard-setting process from being biased by members with economic interests in stifling product competition").

[48] *See* American Society of Mechanical Engineers, Inc. v. Hydrolevel Corp., 456 U.S. 556, 570-74 (1982) (finding that a trade association could be held liable where, under influence of competitors, standards-setting committee issued letter saying that rival's product for a safety device for water boilers was unsafe and in violation of ASME's code); Radiant Burners v. Peoples Gas Light and Coke Co., 364 US 656, 658, 660 (1961) (finding that plaintiff Radiant Burners stated an antitrust claim upon which relief can be granted, where a gas association did not have objective test standards and refused to give seal of approval to plaintiff's ceramic gas burner, gas companies refused to supply gas, and plaintiff thereby was kept from competing).

[49] *See supra* note 36 (illustrating various purposes proscribed by the Maryland state law definition of board certification).

legislature should strongly consider. If, for example, an entrant can persuade physicians, hospitals, payers, and others that it can provide an accurate and cost-effective substitute to certify that medical specialists continue to have up-to-date knowledge, training, experience, and ability to provide quality care in that specialty, then physicians may choose that entrant for their ongoing certification needs and may pass along some of that extra time and lower costs in the form of savings or extra care for consumers. That may also encourage some physicians to seek additional subspecialty certification or to stay in practice longer, as the costs of doing so decline. That may further encourage the incumbent certifying body to continue refining their processes to be competitive in terms of time, cost, and accuracy, thus benefiting those Maryland doctors who do not switch to the entrant and their patients. These potential benefits of entry may be especially meaningful for underserved areas where specialist physicians may already be in short supply.

The Division also strongly urges the Maryland legislature to consider the potential benefits of promoting entry more generally by additional, legitimate certifying bodies, rather than supporting entry on an as-named basis.[50] If other new bodies, unaffiliated with ABMS or NBPAS, can offer a more (or similarly) efficient and accurate way to certify medical specialists, the interests of competition may be better served if they have an opportunity to compete on the merits of their approach with physicians, hospitals, payers, and consumers, without needing new, ad hoc legislation to support their entry.

The Division also encourages the legislature to consider the potential competitive benefits of redefining board certification for state purposes, as per the Workgroup's Bill, so that physicians still qualify as board certified if they lose certification only because they did not participate in MOCs. If medical specialists can establish to hospitals, payers, and patients, based on initial board certification and other indicia, that they can continue to provide up-to-date care without completing an MOC program, then Maryland should consider the competitive benefits of allowing such physicians flexibility to present themselves as board certified and to seek patients, admitting privileges, and reimbursement accordingly. Those indicia could come from a competing certification body that did not provide the initial board certification. Medical specialists certified before their ABMS member board adopted time-limited certifications (colloquially known as grandparents) are already permitted to hold themselves out as board certified without MOC.

[50] The Division does not opine on the particular objective criteria that would define a "legitimate" certifying body. The Division simply urges Maryland to balance its policy objectives to ensure that competition benefits are realized and that certifying bodies operate consistently with a state's public health and consumer welfare objectives.

At the same time, the Division discourages the legislature from interfering with unilateral business decisions—such as an individual hospital's decision about what criteria to use for granting hospital privileges or an individual insurance carrier's decision about what criteria to use for allowing participation in the insurer's network, as restricted in the Workgroup's Bill—unless a restriction is determined to be necessary and narrowly tailored to redress well-founded consumer harms or risks. The Division's long experience protecting competitive markets has led it to understand that free-market competition generally is best served by allowing private actors to make marketplace decisions with minimal interference from government regulation. The Division asks, therefore, whether these restrictions regarding the use of MOCs are necessary and narrowly tailored to address concerns about the certification process. Hospitals and carriers need to identify which physicians merit admitting privileges or inclusion in their network, and they are best situated to determine, based on their individualized needs, whether a particular certification organization's requirements best addresses those needs or whether other indicia are more appropriate. If hospitals and carriers find that physician participation in MOCs furthers these goals efficiently and helps them offer competitive services, Maryland should consider whether the benefits of prohibition outweigh the costs of depriving hospitals and carriers of the right to do business with those doctors they have determined best meet their needs. The Division encourages the Maryland legislature to consider whether other tools, such as facilitating entry by competitive certifying bodies, can address concerns with certification without imposing restrictions on the unilateral business decisions of hospitals and carriers.

IV. Conclusion

The Division is encouraged that the Maryland legislature and the Maryland Health Care Commission are studying specialty board certification and its effect on competition in markets for physician services. The Division recommends that Maryland explore ways to promote competition in specialty board certification without unnecessarily interfering with individual business decision-making.

We appreciate this opportunity to present our views.

Sincerely yours,

Robert Potter
Chief
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