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Board Certification: A Dose of Competition

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In 2014, internists went into [open revolt](#) in response to the American Board of Internal Medicine's (ABIM) new maintenance of certification (MOC) program (a model of measuring continuous learning). The ABIM required physicians to undergo an assessment every two years and a "high stakes" re-certification exam every ten. Internists balked, questioning this new and costly requirement.

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Subsequently, internists and other physicians began to question the long-held dogma that board certification promotes higher-quality, safer care, and they began to examine the private monopoly of the American Board of Medical Specialties (ABMS). Three years later, significant effort and research has revealed the imbalance between certification requirements that impose costly entry barriers for physicians and the limited quality benefits and information for consumers that result.

A two-sided market, board certification provides independent attestations of specialized training to both physicians and consumers of physician services. Hospitals frequently require board certification for granting specialty-specific privileges, thus forcing physicians to purchase not only certification, but also MOC and re-certification from a near-monopoly market as a means of access to continued employment. Patients face increased costs and limited offsetting benefits typical of monopoly markets—recent health care services research has demonstrated no incremental quality gains from MOC and re-certification.

The ABIM's MOC endeavor and its aftermath highlight the need for certification that is designed for and tied to clear quality benefits for patients. This can be achieved through increased competition in the private market for physician board certification, driven by increased antitrust oversight of certifying boards, hospital flexibility in physician credentialing, and joint stakeholder development of gradations of certification tied to meaningful clinical outcomes.

Cautionary Tales In Certification Monopolies: The Example Of Medicare

The Medicare program also provides physicians with a cautionary tale of monopoly in certification. Beginning with Medicare's creation in 1965, federal law expressly and exclusively authorized the Joint Commission to accredit sites as meeting the conditions for Medicare participation. Congress rescinded the exclusivity and irrevocability of the Joint Commission's statutory "deeming authority" in the Medicare Improvements for Patients and Providers Act of 2008 (effective 2010), after a [2004 Government Accountability Office report](#) revealed that the Commission's ability to detect deficiencies in hospital standards was itself deficient. This was consistent with qualitative declines and cost increases associated with monopoly power throughout health care.

Although the Joint Commission has maintained its deeming authority for hospitals and other facilities, that authority now depends on approval from Centers for Medicare and Medicaid Services (CMS); and it is shared with other participants in a market for hospital survey and certification, including Det Norske Veritas Healthcare, Inc. (a subsidiary of Det Norske Veritas, an international certification authority), the Center for Improvement in Healthcare Quality, and others. Competition between market participants promoted innovation and resulted in different survey methodologies and

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assessment criteria, providing health systems with a choice of certification schemas. After the entry of additional accreditation market participants, hospitals could choose a certification program that best fit their needs with either annual or triennial site visits, audits based upon differing methodologies (e.g. tracer or CARE), and either prescriptive or more flexible operational process standards. Additional competitors offered concurrent ISO 9001 certification, while the Joint Commission responded by developing a library of free quality improvement tools for customers. Competition resulted in innovation in an otherwise stagnant and sleepy marketplace.

High Costs, Limited Competition

Physicians face a similar private monopoly, and endure significant costs of achieving and maintaining certification. In order to achieve certification under the American Board of Medical Specialties (ABMS), a physician must apply for and pass a written exam, with an average cost of \$1,846 across all specialties. Some specialties also require a separate oral exam (average cost, \$1,694), while each sub-specialty requires a separate written exam (average cost \$2,060). Thus, a new heart failure cardiologist fresh out of fellowship training would face direct costs of \$7,145 in certification fees for boards in internal medicine, cardiology, and heart failure cardiology.

This burden is even greater when evaluated in the context of a [median of \\$190,000 in medical school debt](#) for the average American medical school graduate. For a hypothetical heart failure cardiologist, this would grow to \$325,000 over the required seven years of post-medical school residency and fellow training.

Maintaining certification also represents a significant barrier to practice. The direct costs of [MOC fees are insignificant](#), estimated at \$257 annually, although many physicians spend thousands of dollars on exam preparation courses and continuous learning modules. When [including the opportunity cost of a busy practitioner's time](#), MOC becomes vastly more expensive to practicing physicians: the only available study estimates that total ten-year costs per physician are \$16,725 for general internists and \$40,495 for medical oncologists. (This study employed a conservative model, assuming that a physician would spend on average of 14 hours each year on MOC education and documentation, rising to 42 hours in the year that a physician takes a certification exam.) Taking into account the nation's physician population, this represents \$5.1 billion in indirect costs resulting from 32.7 million physician-hours. In exchange, physicians gain costly certification from a single, monopolistic board that provides an all-or-nothing market indicator of medical specialization, rather than useful or graded quality information.

Competition amongst competing boards within a specialty would likely spur innovation for initial certification, re-certification, and MOC. Re-certification and MOC are most ripe for change, as even the ABIM notes that its once-every-ten-year certification exam is [problematic](#).

In fact, pressure from alternative boards has already prompted change: the 6,000 member National Board of Physicians and Surgeons does not require a 10-year recertification exam or MOC while the American Board of Physician Specialties requires a re-certification exam but not MOC. These alternative certifying groups, in conjunction with physician pressure, have prompted a few ABMS member boards to reform re-certification and MOC. For example, the American Board of Anesthesiology recently [replaced its high stakes, once-every-ten-year exam](#) with a streamlined process of online learning and quarterly quizzes. Thus, competition between multiple boards within a specialty fosters continued development and study of various MOC mechanisms, such as brief online quizzes, research review, and the incorporation of real-world performance measures.

Lack Of Quality Benefits From Certification

Specialty boards claim that re-certification and MOC increase the quality of care, counterbalancing a natural decline while in practice. Unfortunately, the existing evidence does not support their claim. Prior to 1990, ABIM issued time-unlimited board certification. Subsequently, to maintain certification internists had to pass a once-a-decade exam, and were issued time-limited certificates. The re-certification process does not appear to improve the quality of care delivery: for example, [a retrospective study](#) conducted at four Veterans Affairs Medical Centers, including 105 primary care physicians covering 68,213 patients, found no significant difference on ten primary care performance measures between primary care internists with time-limited certification and those with time-unlimited ABIM certificates. The measures included both process and outcomes measures (such as post-myocardial infarction use of aspirin and hypertension control).

Research on the purported quality benefits of MOC is similarly disappointing: [a retrospective study](#) of nearly 2,000 internists who cared for over 250,000 Medicare beneficiaries (funded by the ABIM itself) demonstrated no change in the annual incidence of ambulatory care-associated hospitalizations, such as the heart failure admission rate or uncontrolled diabetes admission rate, produced by MOC. The researchers did find a small decrease in the rate of growth of medical costs; however, this study did not adjust for multiple comparisons, i.e. the large number of possible positive outcomes of a MOC requirement included in the study. The decreased rate of cost growth might not have been statistically significant had the significance threshold been adjusted to account for these multiple comparisons. These results suggest that physicians can self-educate and provide equivalent quality care using methods outside of the ABIM MOC program.

Standing alone, the demonstrable quality benefits of re-certification and MOC are underwhelming and provide no tangible gains for consumers. Within the context of the high costs imposed upon physicians, the balance of costs-benefits for re-certification and MOC are even lower.

Consumers also experience limited benefits of other types, such as

transparency, from board certification. Board certification functions as an all or nothing signal based upon broad, historically established categories of specialty qualifications. Competition between multiple boards within the same specialty could spur innovation in gradations of certification, potentially providing useful, finer-grained consumer information on a richer array of subject, service, and quality dimensions. Consumers would benefit from more transparent quality information, as well as the lower costs and improved access likely to follow lower barriers to physician entry and mobility.

Hospitals Versus Payers: Differing Views Of Certification

Examining the behavior of other consumers of board certification also demonstrates its limited benefits. Functionally, certification serves as a complement to licensure, signaling that a physician has met enhanced standards of training, knowledge, or procedural skill while demarcating specialties for patients, third-party payers, and health systems. Most hospitals require board certification for granting specialty-specific privileges, using certification as a rough means of signaling competence in certain procedural skills. Where a hospital or network is the dominant provider, certification requirements can function as de facto licensure requirements, instead of optional qualitative signals. Where certification is tied to employment, physicians lack pricing power as long as the cost of certification, MOC, and re-certification do not exceed the cost of leaving the profession.

In contrast, payers carefully weigh the benefits of quality and signaling information against costs and expected restraints on the supply of practitioners. Most major health plans, such as Cigna and Aetna, recognize this cost-access tradeoff and do not require board certification for plan credentialing. Perhaps more convincingly, the CMS does not require board certification for provider enrollment in the Medicare program, which covers over 55 million elderly, disabled, and otherwise vulnerable Americans.

Looking Forward: What Policymakers Should Do

Board certification marks the next phase of competition in health care markets. Physicians face high, path-dependent entry barriers to specialty practice and increasingly high MOC costs. Consumers receive limited signaling information and no quality benefits. Empirical research in other areas of health care has consistently demonstrated the costs of monopoly power, which tends to increase prices while suppressing innovation, access, and even the quality of care.

State lawmakers, learning from the experience of the federal government and the Medicare program, should be wary of enshrining a specific certifying board into state law for medical licensing requirements. Hospitals should recognize the limited signaling benefits of board certification; in addition to accepting multiple certifying bodies for clinical privileges, they should work

with all certifying bodies to help develop meaningful gradations of certification tied to demonstrable quality in care delivery processes and clinical outcomes that are meaningful to patients.

Certifying boards should work with front-line practicing physicians to ensure that initial certification and MOC are not unduly burdensome, in addition to working with state medical boards to ensure that CME and MOC are not duplicative. Antitrust enforcers should focus on attempts to tie licensure and certifying bodies, which would unnecessarily exclude market participants and limit competition amongst certifying bodies.

Competition amongst certifying boards could promote a better future in which physicians experience less onerous requirements to continue to engage in high-quality practice. Competition amongst boards within a specialty could promote price competition, innovation in physician assessment, and the potential for increased signaling information for consumers. Direct government regulation of the details of quality metrics associated with board certification is unnecessary: consumers of certification—physicians, state medical licensing boards, specialty societies, payers, and health systems—would serve as checks against low-value certification programs.

As we seek to create a vision of twenty-first century medical practice, increased competition and subsequent innovation in board certification could empower consumers and reinvigorate medicine.

Authors' Note

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Thank you for this paper. The authors note: "Antitrust enforcers should focus on attempts to tie licensure and certifying bodies, which would unnecessarily exclude market participants and limit competition amongst certifying bodies."

One place to start is with a look at the Interstate Medical Licensure Compact. Obtaining a license via the Compact requires a physician be board certified with either the ABMS or AOA. The FSMB had a major role in developing the compact and was also involved in founding the ABMS and there is a lengthy history of discussions between the FSMB and ABMS of tying certification and MOC to licensure. See for instance: <https://pbs.twimg.com/media...>

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