

2017

Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?

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Antitrust as Disruptive Innovation in Health Care: Can Limiting State Action Immunity Help Save a Trillion Dollars?

*William M. Sage & David A. Hyman**

On February 25, 2015, the United States Supreme Court ruled in North Carolina State Board of Dental Examiners v. FTC that state licensing boards controlled by market participants are subject to federal antitrust law unless they are “actively supervised” by the state itself. The ruling may sound narrow and technical, but the significance of the case can be inferred from the number and prominence of the amici curiae who lined up to support the North Carolina State Board of Dental Examiners (“North Carolina Board”)—first when the Federal Trade Commission’s (“FTC”) internal enforcement action was appealed to the United States Court of Appeals for the Fourth Circuit, and again when that court’s decision in favor of the FTC was reviewed by the Supreme Court.

This Article evaluates the potential of North Carolina State Board to serve as a “disruptive innovation” that will make health care markets more efficient. Over time, the Supreme Court’s holding might induce states to reassess waste and inefficiency in professional services, rein in self-regulatory privilege, and modify political settlements built atop the scaffolding of professional self-governance that unduly constrain markets, even when they do not explicitly violate federal antitrust law. But, that will only happen if states embrace the opening that North Carolina State Board offers to disrupt the status quo.

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INTRODUCTION: WITH FRIENDS LIKE THESE . . .

On February 25, 2015, the United States Supreme Court ruled in *North Carolina State Board of Dental Examiners v. FTC* that state licensing boards controlled by market participants are subject to federal antitrust law unless they are “actively supervised” by the state itself.¹ The ruling may sound narrow and technical, but the significance of the case can be inferred from the number and prominence of the amici curiae who lined up to support the North Carolina State Board of Dental Examiners (“North Carolina Board”)—first when the Federal Trade Commission’s (“FTC”) internal enforcement action was appealed to the United States Court of Appeals for the Fourth Circuit,² and again when that court’s decision in favor of the FTC was reviewed by the United States Supreme Court.

1. 135 S. Ct. 1101 (2015).

2. N.C. State Bd. of Dental Exam’rs v. FTC, 717 F.3d 359, 365 (4th Cir. 2013).

Before the Fourth Circuit, the North Carolina Board had the backing of twenty-four “friends of the court”: twelve prestigious professional organizations and twelve licensing boards or organizations of licensing boards.³ When the case went before the Supreme Court, the North Carolina Board’s amici were even more impressive—including twenty-four states and three state-level associations, eighteen licensing boards or organizations of licensing boards, and seventeen professional associations.⁴ When professional bodies this diverse and prominent go to court to defend self-regulatory prerogatives that they have enjoyed for many decades, they do not expect to lose.⁵ Yet the Supreme Court bluntly

3. The professional organizations were: American Academy of Pediatric Dentistry, American Academy of Periodontology, American Association of Dental Boards, American Association of Orthodontists, American Dental Association, American Medical Association, American Osteopathic Association, American Veterinary Medical Association, Medical Society of Virginia, North Carolina Medical Society, South Carolina Medical Association, and West Virginia State Medical Association. The licensing boards or organizations of licensing boards were: American Association of Veterinary State Boards, Association of Social Work Boards, Federation of Associations of Regulatory Boards, Federation of Chiropractic Licensing Boards, Federation of State Boards of Physical Therapy, Federation of State Massage Therapy Boards, Federation of State Medical Boards, International Conference of Funeral Service Examining Boards, Inc., National Association of Boards of Pharmacy, National Association of Long Term Care Administrator Boards, National Board for Certification in Occupational Therapy, and North Carolina Board of Pharmacy. Brief of the American Dental Association, American Medical Association et al. as Amici Curiae Supporting Petitioner, *N.C. State Bd. of Dental Exam’rs*, 135 S. Ct. 1101 (No. 13-534).

4. The list of states and state-level associations was: Alabama, Arizona, Arkansas, Colorado, Connecticut, Council of State Governments, Delaware, Florida, Hawaii, Idaho, Indiana, Kansas, Kentucky, Maryland, Michigan, National Conference of State Legislatures, National Governors Association, Nebraska, North Carolina, Ohio, Oregon, South Carolina, Tennessee, Utah, Virginia, and West Virginia. The list of licensing boards or organizations of licensing boards was: American Association of Dental Boards, American Association of Veterinary State Boards, American Association of State Counseling Boards, Association of Regulatory Boards of Optometry, Association of Social Work Boards, Association of State and Provincial Psychology Boards, Federation of State Boards of Physical Therapy, Federation of Associations of Regulatory Boards, Federation of State Medical Boards, Federation of Chiropractic Licensing Boards, Federation of State Massage Therapy Boards, International Conference of Funeral Service Examining Boards, Inc., and National Council of Examiners for Engineering and Surveying, National Council of State Boards of Nursing, National Association of Long Term Care Administrator Boards, National Association of Boards of Pharmacy, National Association of State Boards of Accountancy, and North Carolina Board of Law Examiners. The list of professional organizations was: American Academy of Pediatric Dentistry, American Association of Orthodontists, American Medical Association, American Dental Association, American Osteopathic Association, American Society of Anesthesiologists, American Veterinary Medical Association, California Optometric Association, Florida State Bar, Medical Society of North Carolina, Medical Society of South Carolina, Medical Society of Virginia, Medical Society of West Virginia, National Association of State EMS Officials, Nevada State Bar, North Carolina State Bar, and West Virginia State Bar. Brief for the State of West Virginia and 9 Other States as Amici Curiae Supporting Petitioner, *N.C. State Bd. of Dental Exam’rs*, 135 S. Ct. 1101 (No. 13-534).

5. By comparison, the FTC had only one “friend” before the United States Court of Appeals for

upheld the use of federal antitrust law to police anticompetitive conduct by a state licensing board controlled by those it purported to regulate. The fact that professional organizations lost—and lost so decisively—marks a change in elite (and likely public) perceptions of the professions. In the array of amici, the Supreme Court saw not a guardian force serving the public interest, but a multi-headed hydra using a cloak of state authority to devour its prey.

It helped that the Sherman Antitrust Act is no ordinary federal law. Scholars label the Sherman Act a “super-statute” that reflects and instantiates free enterprise as a fundamental value in American society.⁶ When a law is regarded as a super-statute, it becomes:

one of the baselines against which other sources of law—sometimes including the Constitution itself—are read. Ordinary rules of construction are often suspended or modified when such statutes are interpreted. Super-statutes tend to trump ordinary legislation when there are clashes or inconsistencies, even when principles of construction would suggest the opposite. Occasionally, super-statutes can reshape constitutional understandings. Because super-statutes exhibit this kind of normative gravity, they have sufficient attraction to bend and reshape the surrounding landscape.⁷

Framed this way, the Court’s blunt rejection of the dentists’ claim of professional privilege is less surprising.

Even so, two fundamental principles of federal jurisprudence dictated the opposite result: respect for states as sovereign entities (i.e., federalism); and judicial deference to political actors, even those that may have been captured by special interests. Had the Court been swayed by these competing principles, it would have told the FTC (and federal antitrust law) to butt out. Beginning with its 1943 decision in *Parker v. Brown*, the Supreme Court has consistently held that Congress did not

the Fourth Circuit: the American Antitrust Institute. When the case made it to the Supreme Court, the FTC had more “friends,” but they were drawn from less prestigious professional associations (e.g., the American Association of Nurse Anesthetists, the American Association of Nurse Practitioners, and the American College of Nurse Midwives); think tanks (e.g., the Cato Institute, the Pacific Legal Foundation, and Public Citizen, Inc.); a few legal technology companies (e.g., LegalZoom.com, Fileright, JustAnswer, and Shake); and a gaggle of law professors. Brief for the American Antitrust Institute as Amicus Curiae Supporting Respondent, *N.C. State Bd. of Dental Exam’rs*, 135 S. Ct. 1101 (No. 13-534).

6. A super-statute is a law that “(1) establish[es] a new normative or institutional framework for state policy and (2) over time does ‘stick’ in the public culture such that (3) the super-statute and its institutional or normative principles have a broad effect on the law—including an effect beyond the four corners of the statute.” William N. Eskridge, Jr. & John Ferejohn, *Super-Statutes*, 50 DUKE L.J. 1215, 1216 (2001).

7. *Id.*

intend the Sherman Act to override state regulation.⁸ If North Carolina dentists were using state licensing authority to screw up the market for dental services, *Parker* and subsequent decisions indicated that problem was none of the federal government's business—and the sovereign state of North Carolina should be left to sort things out, or not, as it saw fit.

That said, the facts were not on the dental profession's side. Practicing dentists who controlled the North Carolina Board had sent cease-and-desist letters to small teeth-whitening businesses and the shopping malls that housed them—and these letters threatened criminal prosecution for the unlicensed practice of dentistry.⁹ Because the North Carolina Board lacked specific statutory authorization from the state legislature both to define the alleged legal violation and to level the accusation in the form taken, the FTC brought an enforcement action to reverse what it considered overtly anticompetitive conduct not protected by “state action” immunity. The fact that so many professional boards and associations lined up behind the North Carolina dentists in a case with bad facts *and* bad law speaks volumes about the self-interested parochialism of the professions.

A truism of litigation is that when both the facts and the law are against you, pound the table and argue public policy. To the North Carolina Board's amici, compelling considerations of expertise, ethics, and public safety combined to add “professional sovereignty” to the balance as a third fundamental principle—and, in their view, tipped the scales of justice conclusively in favor of the North Carolina Board. Yet the Court resolved the conflict between a free enterprise super-statute and three established doctrines arguing for judicial restraint with a clear smackdown of professional monopoly. Moreover, by condemning a state licensing body, the Court shook the foundation of self-regulatory authority that politically powerful professions have used to rig the rules of the service delivery game in their favor.

The Supreme Court likely regarded the dentists' conduct, however reprehensible, more as hubris than as inefficiency. Allowing nondentists to offer cheap, safe tooth whitening will not make dentistry as a whole cheaper or safer. Still, the Court would not have reached its conclusion

8. *Parker v. Brown*, 317 U.S. 341, 363 (1943).

9. Teeth whitening in North Carolina was available from dentists, either as an in-office service or in a take-home form; as an over-the-counter product; and from nondentists in salons, shopping malls, and other locations. The version provided by dentists was more powerful and required fewer treatments, but was significantly more expensive and less convenient. In response to complaints by dentists that nondentists were providing lower-cost teeth-whitening services, the North Carolina Board sent dozens of stern letters threatening official action. There were no complaints by consumers about the quality of teeth-whitening services that they were receiving—let alone evidence of consumer harm. *N.C. State Bd. of Dental Exam'rs*, 135 S. Ct. at 1108.

had it kept to the conventional wisdom that markets for learned professions such as dentistry, medicine, and law work better when external influences on their collective decisions are minimized. And once one begins to see the affordability of high-quality professional services as an intrinsic rather than an external challenge, the use of antitrust law to constrain self-interest, reduce waste, and enhance consumer choice becomes much more attractive. This is particularly true for our health care system, which wastes approximately \$1 trillion every year on overpriced, unnecessary, and ineffective services.¹⁰

Antitrust law is frequently and properly charged with policing combinations of large corporations that threaten to harm consumers through monopoly or oligopoly pricing. Although consolidation of this sort is an increasing problem in health care—particularly in the hospital, health insurance, and pharmaceutical sectors—anticompetitive risks have arisen more frequently from coordinated behavior among independent physicians practicing in local markets for health care services. Antitrust authorities have worked for decades to combat these restraints of trade, but the *North Carolina State Board* decision goes to the heart of the issue by confronting professional self-protection under color of state law.

This Article evaluates the potential of the *North Carolina State Board* decision to serve as a “disruptive innovation” that can make health care markets more efficient. Over time, the Supreme Court’s holding might induce states to reassess waste and inefficiency in professional services, rein in self-regulatory privilege, and modify political settlements built atop the scaffolding of professional self-governance that unduly constrain markets, even when they do not explicitly violate federal antitrust law. Part II explains the deep legal architecture that is a root cause of flawed competition in United States health care and identifies ways in which state licensing boards contribute to the problem. Part III explores the impact to date of *North Carolina State Board*. Part IV sketches paths of greater or lesser health care innovation that might follow *North Carolina State Board* and concludes with some general observations on the challenges associated with the federal government’s concurrent responsibilities as health care payor, regulator, and antitrust enforcer.

I. THE \$1 TRILLION LEGAL PROBLEM OF FLAWED COMPETITION IN HEALTH CARE

Health care in the United States faces a crisis of quality and value.

10. Nikhil Sahni et al., *How the U.S. Can Reduce Waste in Health Care Spending by \$1 Trillion*, HARV. BUS. REV. (Oct. 13, 2015), <https://hbr.org/2015/10/how-the-u-s-can-reduce-waste-in-health-care-spending-by-1-trillion>.

With expenditures of \$3.2 trillion annually, the United States health care system is by far the world's most costly but is certainly not the best in terms of quality. Health care services are poorly accessible, fragmented, and unreliable. Preventive care is neglected. Adherence even to well-established clinical "best practices" is uncommon. Medical errors are frequent. Patients' goals and concerns go unmet. Social problems are frequently medicalized but seldom addressed. Moreover, by several estimates, approximately \$1 trillion is wasted each year for care that is nearly always overpriced, frequently useless, sometimes harmful, and, often fraudulent.

A. From "Iron Triangle" to "Triple Aim"

Until recently, medically miraculous but expensive technology was considered the principal driver of health care costs. But now, services that are overpriced, inefficiently produced, and ineffectively delivered are recognized as the engines of overspending. This reframing has profound implications for domestic health policy.

In a book titled *Medicine's Dilemmas: Infinite Needs Versus Finite Resources*, academic physician William Kissick asserted: "No society can provide all the services its population is able to utilize."¹¹ In economic terms, Kissick's formulation placed health care expenditures on a Pareto frontier, making "guns or butter" tradeoffs necessary. Kissick therefore conceived of access to care, its quality, and its cost as constituting what political scientists call an "Iron Triangle": public policies improving performance on one or two of the objectives would necessarily worsen performance on the remaining objectives.¹² For these reasons, deliberate rationing would become necessary to constrain health care spending.

But what if health care was just massively inefficient? Research at Dartmouth documented unjustified variation in clinical practices and associated costs.¹³ Other studies demonstrated systematic problems with

11. WILLIAM KISSICK, *MEDICINE'S DILEMMAS: INFINITE NEEDS VERSUS FINITE RESOURCES* 48 (1994).

12. *Id.* at 2–3.

13. These substantial, unexpected geographic variations in medical treatment were not associated with either greater health care needs or superior clinical outcomes. *Understanding of the Efficiency and Effectiveness of the Health Care System*, DARTMOUTH ATLAS HEALTH CARE (2015), <http://www.dartmouthatlas.org> (last visited Apr. 17, 2017). It became clear that "best practices" were seldom available, outcomes of care were typically unmeasurable, and clear advances in medical knowledge often took years to diffuse into communities and alter the habits of local physicians.

quality and safety.¹⁴ There was renewed interest in population health and attention to “social determinants” of health. Payment models based on private sector management gained popularity. Although the “managed care” revolution of the 1990s proved to be cumbersome and unpopular, the Iron Triangle concept of national health policy slowly gave way to an alternative vision: the “Triple Aim.”

The “Triple Aim,” which was the brainchild of Harvard pediatrician Donald Berwick and his Institute for Healthcare Improvement, consists of *simultaneously* improving the patient experience of care (including quality and satisfaction), improving the health of populations, and reducing the per capita cost of health care.¹⁵ The “Triple Aim” therefore integrates individual and population health, takes the existing health care system off the Pareto frontier, and makes the “value” of health care (both its productive and its allocative efficiency) the central inquiry. Moreover, instead of waiting for a definitive political solution, the “Triple Aim” emphasizes the importance of decentralized incremental improvements.

B. Waste, Law, and the Medical Profession

Although a variety of imperfections in information and incentives diminish the value proposition of the current health care system, the principal source of wastefulness is the American medical profession, which not only enjoys substantial self-regulatory privileges but also receives generous public subsidies for its work.¹⁶ Although

14. Many beneficial treatments are underused, while other expensive, risky therapies are overused. Misuse is also common, resulting in medical errors. Mark R. Chassin, Robert W. Galvin & the National Roundtable on Health Care Quality, *The Urgent Need to Improve Health Care Quality: Institute of Medicine National Roundtable on Health Care Quality*, 280 JAMA 1000, 1000 (1998). Similar evidence accumulated regarding iatrogenic (physician-induced) injury; based on this evidence, the Institute of Medicine (“IOM”) estimated in 1999 that medical errors kill 44,000–98,000 hospitalized patients annually. INST. OF MED., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 26 (Linda T. Kohn ed., 1st ed. 2000). A recent meta-analysis in the *Journal of Patient Safety* concluded that “preventable harm to patients” causes more than 400,000 premature deaths each year, making medical error the third leading cause of death in the United States. John T. James, *A New, Evidence-Based Estimate of Patient Harms Associated with Hospital Care*, 9 J. PATIENT SAFETY 122, 125 (2013).

15. *IHI Triple Aim Initiative*, INST. FOR HEALTHCARE IMPROVEMENT (2015), <http://www.ihl.org/Engage/Initiatives/TripleAim/pages/default.aspx> (last visited Sept. 8, 2016). Berwick served for just over a year as director of the Centers for Medicare and Medicaid Services, pursuant to a recess appointment.

16. The IOM has attributed over \$750 billion each year to waste. INST. FOR MED., BEST CARE AT LOWER COST: THE PATH TO CONTINUOUSLY LEARNING HEALTH CARE IN AMERICA 38 (Mark Smith et al. eds., 2012). Of this amount, an estimated \$210 billion reflects unnecessary services, including overuse not justified by scientific evidence, discretionary use beyond established benchmarks, and unnecessary choice of higher-cost services. *Id.* at 102. The IOM identified another \$130 billion in inefficiently delivered services, including medical errors, preventable

approximately two-thirds of health care spending is controlled by physicians, a relatively small percentage is retained by them personally. Most of the money is directed elsewhere (i.e., to hospital care, post-acute services, diagnostic testing, pharmaceuticals, medical equipment, and consultations from other professionals). It is for this reason that the most expensive piece of equipment in a modern hospital is often said to be the physician's pen (or, these days, keyboard).

Physicians possess this power for a simple reason: the body of doctrines and practices that we call "health law" systematically supports it. Laws protect the public from individuals and therapies not controlled by physicians, and discourage medical self-help. Laws fund physicians' tools and assure their quality—though unfortunately not their value. Laws mandate and subsidize insurance coverage for the treatments physicians recommend. Laws insulate physicians from corporate structures and contractual norms. Laws mediate disputes between physicians and patients based on professional standards. Laws apply medical criteria to most ethical issues. Finally, laws such as those challenged in *North Carolina State Board* delegate substantial rule making and disciplinary authority to state licensing boards (i.e., to entities populated from, and controlled by, the medical profession). States typically justify this abdication of direct oversight in terms of physicians' scientific expertise, and their ethical duty to heal, not harm, patients.

Both individually and collectively, these laws profoundly distort competition in health care and severely hamper the market's ability to generate the benefits of competition that we see in other industries. Production remains fragmented. Prices are both inflated and arbitrary—and price competition is minimal (when it even exists at all). There are many barriers to competitive entry—even to deliver the most basic services. Geographic markets are needlessly small and are surprisingly concentrated. Supply bottlenecks are common, often to the mutual benefit of large health insurers and dominant health care providers. And innovation is limited to the sorts of inputs that fit into existing production processes—mainly drugs, diagnostics, and medical devices.

The result is that our health care system almost never trades in the types of consumer products that dominate other costly, complex,

complications, fragmented care, unnecessary use of higher-cost providers, and operational inefficiency at care delivery sites. *Id.* Excess administrative costs accounted for \$190 billion, missed prevention opportunities for \$55 billion, and fraud for \$75 billion. *Id.* The IOM's final category, amounting to \$105 billion in annual waste, is "Prices That Are Too High"—meaning that they exceed competitive benchmarks. *Id.* Considerable research has suggested that high and arbitrary prices rather than excessive utilization of care are primarily responsible for the United States' aberrantly large medical expenditures compared to other countries.

technologically sophisticated industries. Instead of fully assembled products accompanied by a strong performance warranty, patients are expected to pay for disaggregated professional process steps (including procedures and consultations) to which billing codes have been assigned, and for equally atomized inputs and complements to those professional processes (such as diagnostic tests and surgical supplies). Health insurance agglomerates these unstructured procedural steps and physical inputs into “covered benefits,” but it does not assemble them into actual, useful products—and only a few true Health Maintenance Organizations (“HMOs”) provide comprehensive prepaid care.

The past decade has witnessed growing agreement regarding both the necessary attributes of a high-performing health care system,¹⁷ and the managerial strategies for achieving them.¹⁸ Much less attention has been paid to the legal obstacles that have long hindered attempts to redesign acute and complex care—let alone to moving the locus of basic care “upstream,” where it can be communally or self-administered, rather than professionally controlled. As currently constituted, American health law presents concrete structural impediments to accomplishing these consensus health policy goals, and also creates opportunities for incumbent providers to delay or sabotage such efforts.

C. *Anticompetitive Effects of Medical Licensing*

The deep legal architecture of health care strongly favors physician self-regulation, and furthers physicians’ professional insularity and self-interest. Physician-controlled medical licensing boards have attracted

17. In a book-length report, the IOM succinctly stated the six core characteristics of a high-performing health care system: (i) “safe: avoiding injuries to patients from the care that is intended to help them”; (ii) “effective: providing services based on scientific knowledge to all who could benefit and refraining from providing services to those not likely to benefit”; (iii) “patient-centered: providing care that is respectful of and responsive to individual patient preferences, needs, and values, and ensuring that patient values guide all clinical decisions”; (iv) “timely: reducing waits and sometimes harmful delays for both those who receive and those who give care”; (v) “efficient: avoiding waste, including waste of equipment, supplies, ideas, and energy”; and (vi) “equitable: providing care that does not vary in quality because of personal characteristics such as gender, ethnicity, geographic location, and socioeconomic status.” INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* 39–40 (2001).

18. As two leading experts in health care management state: “There is no longer any doubt about how to increase the value of care.” Michael E. Porter & Thomas H. Lee, *The Strategy That Will Fix Health Care*, HARV. BUS. REV. (Oct. 2013), <https://hbr.org/2013/10/the-strategy-that-will-fix-health-care>. The standard toolkit for pursuing value includes measuring costs and outcomes, expecting payment only for successful care, building “integrated practice units,” and embracing health information technology. Successfully launching these innovations depends critically on effective competition in the marketplace. MICHAEL E. PORTER & ELIZABETH O. TEISBERG, *REDEFINING HEALTH CARE: CREATING VALUE-BASED COMPETITION ON RESULTS* 172 (2006).

criticism for decades. Milton Friedman famously wrote in 1962:

I am . . . persuaded that [restrictive] licensure has reduced both the quantity and quality of medical practice; . . . that it has forced the public to pay more for less satisfactory medical service[;] and that it has retarded technological development both in medicine itself and in the organization of medical practice.¹⁹

At the time he made it, Friedman's harsh economic critique of occupational licensing was not widely shared (except among other libertarians). Professional elites were thought to represent a progressive, prosperous alternative to industrial commodification and the supposed exploitation of labor. To be sure, there was some recognition that the professions might use ethical codes to pursue their own economic self-interest.²⁰ But mainstream economists such as Kenneth Arrow still believed that collective professionalism improved the marketability of health care by fostering the trust needed to overcome medical uncertainty and informational asymmetry between physicians and patients.²¹ More recently, a wide array of voices have questioned the economics, and even the justice, of professional privilege.²² In 2015, the Obama Administration issued a report on occupational licensing, finding that "licensing can . . . reduce employment opportunities and lower wages for excluded workers, and increase costs for consumers," and that "the costs of licensing fall disproportionately on certain populations."²³

19. MILTON FRIEDMAN, *CAPITALISM AND FREEDOM* 149–59 (1962).

20. Compare Talcott Parsons, *Professions*, in 12 *INTERNATIONAL ENCYCLOPEDIA OF THE SOCIAL SCIENCES* 536, 545 (David L. Sills ed., 1968) (noting that professions have "become the most important single component in the structure of modern societies"), with ELIOT FREIDSON, *PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE* (1970) (arguing that the medical profession has become too powerful and too autonomous).

21. Kenneth Arrow, *Uncertainty and the Welfare Economics of Medical Care*, 53 *AM. ECON. REV.* 941, 965 (1963).

22. Aaron Edlin & Rebecca Haw, *Cartels by Another Name: Should Licensed Occupations Face Antitrust Scrutiny?*, 162 *U. PA. L. REV.* 1093, 1096–97 (2014); Alexander Volokh, *The New Private Regulation Skepticism: Due Process, Non Delegation, and Antitrust Challenges*, 37 *HARV. J.L. & PUB. POL'Y* 931, 933 (2014).

23. THE WHITE HOUSE, *OCCUPATIONAL LICENSING: A FRAMEWORK FOR POLICYMAKERS* (July 2015), <https://search.archives.gov/search?query=Occupational+Licensing%3A+A+Framework+for+Policymakers+&op=Search&affiliate=obamawhitehouse> (follow "Occupational Licensing: A Framework for Policymakers" hyperlink). The report's executive summary notes that: (i) "by imposing additional requirements on people seeking to enter licensed professions, licensing can reduce total employment in the licensed professions"; (ii) "unlicensed workers earn 10 to 15 percent lower wages than licensed workers with similar levels of education, training, and experience"; (iii) licensing laws lead to higher prices for goods and services, with research showing effects on prices of between 3 and 16 percent . . . [but often] did not increase the quality of goods and services"; (iv) about 35 percent of military spouses in the labor force work in professions that require State licenses or certification, and . . . may have difficulty acquiring a new license each time they move";

To be sure, medical licensing laws are not solely to blame for health care's competitive shortcomings. Other federal and state regulations and subsidies bear responsibility as well. Still, licensing boards set the tone for the rest of health law as gatekeepers into the health professions and arbiters of practice once admitted. These boards determine the permitted scope of practice, confer authority to write prescriptions, police departures from conventional patterns of care, respond to complaints by licensees about outsiders, and decide when (and, usually, when not) to take disciplinary action against a licensed professional.

From a health policy perspective, physician-imposed barriers to market entry and innovation—typically enforced by a professional licensing board—are the most pernicious practice. Licensing boards set standards for acceptability and impose discipline on licensees who violate their dictates. Unlicensed practice is a criminal act. These entry barriers not only deter novel approaches from new directions, such as telehealth and various “upstream” self-care modalities, but they also discourage existing competitors from adopting practices introduced to the market by disruptive innovators.

Medical licensing boards also reinforce norms of physician primacy that limit the ability of other licensed health professionals to enter the market, even when they have extensive training in diagnosis and treatment. For example, the scientific case for expanding nursing practice is well established, but Texas and a few other states still deny advanced practice nurses the ability to practice independently.²⁴ If these barriers to entry are directly imposed by politically accountable state legislatures, then they are immune from federal antitrust scrutiny. But when physicians use medical licensing boards to impose similar restraints, the antitrust laws can help push back—particularly given the resulting loss of competition, innovation, and economic opportunity for advanced practice nurses.²⁵

II. NORTH CAROLINA STATE BOARD AND ITS IMMEDIATE AFTERMATH

There have been only limited changes since Friedman's scathing criticism in 1962 of medical licensing boards. Reforms have typically added a few lay or nonphysician members to licensing boards and

and (iv) “licensing requirements often make it difficult for immigrants to work in fields where they have valuable experience and training.” *Id.* at 4–5.

24. INST. OF MED., THE FUTURE OF NURSING: LEADING CHANGE, ADVANCING HEALTH 22–23 (Oct. 5, 2011); *Implementation Status Map*, NAT'L COUNCIL ST. BOARDS NURSING, <https://www.ncsbn.org/5397.htm> (last updated Aug. 22, 2016).

25. Daniel J. Gilman & Julie Fairman, *Antitrust and the Future of Nursing: Federal Competition Policy and the Scope of Practice*, 24 HEALTH MATRIX 143, 149–50 (2014).

increased transparency regarding disciplinary actions against licensees. These changes may have made licensing boards more open to new modalities of care that extend physician capacity, but they are still likely to obstruct the development of products and services that promote self-care without the need for physician consultation or control. Aggressively applied, the *North Carolina State Board* standard can deter such anticompetitive conduct, thereby facilitating market entry and broader innovations in care delivery.

A. State Action and Professional Regulation

If private parties conspire with one another to restrain competition, they may face civil and criminal sanctions for violating antitrust law. But, as noted above, courts have inferred congressional intent to let state laws stand that depart from competitive norms—and Congress has never declared that inference incorrect.²⁶ Consistent with fundamental conceptions of federalism, states may enact legislation that flatly contravenes federal antitrust law and may even shelter private actors from antitrust challenge, so long as the state satisfies two conditions.²⁷ The state must *clearly articulate* its purpose to substitute a less competitive regime,²⁸ and the state must *actively supervise* private parties whose conduct would otherwise be unlawfully anticompetitive.²⁹

Over the years, health care providers have taken generous advantage of this invitation to obtain state authorization of anticompetitive conduct. Often, providers' interest in reducing competition aligned with more general concerns about cost or quality, resulting in all-payer rate regulation, certificate-of-need requirements for capital investment, nonphysician scope of practice restrictions, and similar measures. In the 1990s, physicians in several states sought antitrust exemptions so they could bargain collectively with HMOs over fees, but were unsuccessful at securing such a blanket privilege to cartelize. More recently, hospital systems in some regions have negotiated Certificates of Public Advantage ("COPAs") with state governments, allowing them to act as (lightly) regulated monopolies. In most of these situations, the federal

26. See *supra* text accompanying note 8 (noting how since its decision in *Parker v. Brown*, the Supreme Court has found that Congress did not intend the Sherman Act to override state regulation).

27. *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 99, 105 (1980).

28. A municipality or other nonsovereign political subdivision or public actor may adopt anticompetitive laws or ordinances without active supervision by the state, but the state must still clearly articulate the authority it has conferred. *FTC v. Phoebe Putney Health Sys., Inc.*, 133 S. Ct. 1003, 1006 (2013).

29. *N.C. State Bd. of Dental Exam'rs v. FTC*, 135 S. Ct. 1101, 1110 (2015).

antitrust enforcement agencies have been powerless to do more than register their objections publicly, often through correspondence with state legislative and executive branch leadership under the FTC's program of "competition advocacy." Going forward, however, the combination of *North Carolina State Board* with the Supreme Court's 2013 decision in *FTC v. Phoebe Putney Health System, Inc.*³⁰ may reinvigorate federal antitrust challenges to hospitals' assertions of self-regulatory privilege.

Many questions nonetheless remain about the permissibility of specific state medical board practices post-*North Carolina State Board*. The tradition of collective self-governance among the professions gives rise to a variety of organized entities that enroll members, adopt policies, articulate standards, and engage the public. Some are indisputably private, voluntary associations, while others play quasi-public roles as certifiers of quality and fitness, and still others—such as licensing boards—are designated as state agencies.

The Supreme Court has long finessed the issue of whether legislatively chartered self-regulatory entities, such as licensing boards, are definitively public bodies. In *Goldfarb v. Virginia State Bar*, for example, the Supreme Court noted only that the State Bar was a state agency in Virginia for some "limited purposes."³¹ In *Goldfarb*, however, the State Bar's role in restraining competition was indirect. An unquestionably private county bar association published a fee schedule for its members that listed prices for title review services, but that schedule was binding only because the State Bar issued ethical opinions declaring compliance with county bar schedules to be a professional obligation. Importantly, the state judiciary never reviewed these ethical opinions, so there was no possibility of active supervision.

In North Carolina, by contrast, the state dental board directly imposed the restraint of trade. Six of the eight spots on the North Carolina Board were required to be held by North Carolina licensed dentists, who were elected by their peers to serve. In denying state action immunity, the Court emphasized that the North Carolina Board was composed of a majority of practicing members of the profession it regulated.³² As a result, the Court applied active supervision requirements to an administrative body of a sovereign state that it would not have applied to

30. 133 S. Ct. 1003, 1017 (2013) (rejecting a state action defense in a proposed merger to monopoly involving a public hospital system that had been given general corporate powers by the State of Georgia).

31. *Goldfarb v. Va. State Bar*, 421 U.S. 773, 791 (1975) ("The fact that the State Bar is a state agency for some limited purposes does not create an antitrust shield that allows it to foster anticompetitive practices for the benefit of its members.")

32. *N.C. State Bd. of Dental Exam'rs*, 135 S. Ct. at 1114.

a nonsovereign municipality.

But the Court did not specify the exact meaning of “active supervision” for a licensing board, nor did it definitively resolve the dental board’s legal status as public or private. This makes it difficult to know if the Court’s condemnation of anticompetitive board conduct will have a lasting effect on self-regulatory practices at the state level, or whether the ruling’s potentially sweeping implications for nonconflicted public oversight of professions will be evaded through a combination of politics-as-usual in statehouses and collateral attacks in court.

B. Litigation After North Carolina State Board

Litigation citing *North Carolina State Board* is already underway— involving both state licensing boards and other state agencies whose decisions affect professionals. The current status of more than a dozen cases, involving a wide array of licensed professionals, is summarized below – broken out by area of specialty.

1. Medicine

Teladoc, a Dallas-based company that contracts with licensed Texas physicians to provide telephonic consultations to patients within the state, filed a high-profile private antitrust lawsuit against the Texas Medical Board (“TMB”).³³ Teladoc physicians sometimes prescribe medications during telephonic sessions, a practice that the TMB attempted to eliminate over the last several years using an increasingly stringent set of interpretations and amendments to its longstanding Rule 190.8, which prohibits prescriptions unless a physician-patient relationship is clearly established.³⁴ According to the TMB, that relationship can only be established by an in-person physical examination performed by the physician, or by presentation of the patient to the physician by another health professional using a high-resolution video connection.³⁵

After *North Carolina State Board* was decided, Teladoc filed an antitrust complaint, claiming that the TMB’s prohibition on prescribing after telephonic consultation enhances the market power of Texas-licensed physicians. Teladoc is a corporation, not an individual licensee, and its innovative system of telephonic consultation is less personal, but significantly cheaper, than conventional face-to-face medical care.

33. *Teladoc, Inc. v. Tex. Med. Bd.*, 112 F. Supp. 3d 529, 533 (W.D. Tex. 2015).

34. *Id.* at 533–34 (referencing 22 TEX. ADMIN. CODE § 190.8 (2017)).

35. The Texas Medical Board (“TMB”) initially sought to achieve its goals by enacting an “emergency rule” in January 2015. *Id.* at 534. That rule was stayed by the courts for lack of a demonstrated emergency. *Id.* TMB subsequently amended the rule in May 2015 to explicitly require an in-person consultation. *Id.*

Complaints about Teladoc were brought to the medical board by physicians who were Teladoc's actual or potential competitors. None of Teladoc's customers complained about their services. Like many states, the Texas legislature had explicitly addressed telephonic prescription in connection with Medicaid's coverage of telemedicine, but it had left judgments regarding what constitutes ethical practice of the profession outside the coverage context to the state's medical board. The TMB's decision to expand the scope of Rule 190.8 was based largely on the board members' personal experiences and beliefs regarding appropriate medical care, and not on empirical evidence of risk or harm to patients.

Because twelve of the TMB's nineteen members were licensed physicians, the dispute fit squarely within the *North Carolina State Board* holding. A federal district court granted Teladoc a preliminary injunction temporarily restraining enforcement of the new rule.³⁶ TMB subsequently sought to have the case dismissed, arguing that its rule-making processes are actively supervised because its decisions are subject to judicial review by Texas courts, the State Office of Administrative Hearings, and the Texas legislature. The district court denied immunity, and TMB sought immediate appellate review under the collateral order doctrine.³⁷ Unlike *North Carolina State Board*, however, the majority of amicus briefs filed in the United States Court of Appeals for the Fifth Circuit supported Teladoc, including a brief from the FTC and the Department of Justice ("DOJ").³⁸ Perhaps for this reason, TMB voluntarily withdrew its appeal on October 17, 2016, returning the case to the district court for trial. Given this uncertainty, the Texas telehealth industry negotiated a compromise bill, including new standards for teleprescribing. The bill, which was recently enacted by the Texas legislature, and is awaiting the signature of the governor, is likely to

36. Teladoc also argued that TMB's new policies violated the Commerce Clause. *Id.*

37. *Id.* at 535. Warning: the remainder of this footnote is for civil procedure junkies. While the case was pending before the United States Court of Appeals for the Fifth Circuit, the American Antitrust Institute filed an amicus brief arguing that the lower court's decision was not appealable as a collateral order. Brief for the American Antitrust Institute as Amicus Curiae Supporting Neither Party, *Teladoc, Inc. v. Tex. Med. Bd.*, No. 1-15-CV-343-RP, 2015 WL 8773509 (W.D. Tex. Dec. 14, 2015) (No. 16-50017). In response, TMB returned to the district court, and sought to have the order certified for appeal, pursuant to 28 U.S.C. § 1292(b)—six months and twenty-two days after the original order denying state action immunity was issued. *Teladoc, Inc.*, 1:15-CV-343-RP, 2016 WL 4362208 (W.D. Tex. Aug. 15, 2016). The district court held that the request for certification was untimely. *Id.* at *1.

38. See Brief for the United States and the Federal Trade Commission as Amici Curiae Supporting Plaintiffs-Appellees, *Teladoc, Inc. v. Tex. Med. Bd.*, No. 16-50017 (5th Cir. June 27, 2016) (arguing that the Fifth Circuit first lacks jurisdiction to hear the appeal and second, that even if that court has jurisdiction, the court should affirm the district court's order and reject the Board's argument that its rules are shielded from federal antitrust scrutiny by the "state action" doctrine).

render the litigation moot.³⁹

In *Baker County Medical Services, Inc. v. Florida*, a hospital sued Florida's Agency for Health Care Administration ("AHCA") and a competing corporation, seeking a declaratory judgment that a certificate of need issued to the competing corporation was expired.⁴⁰ The Florida circuit court dismissed the complaint, but the First District Court of Appeal of Florida held that the AHCA had exceeded its statutory authority in approving a settlement agreement that extended the certificate of need. The court cited to *North Carolina State Board* for the proposition that "when a State empowers a group of active market participants to decide who can participate in its market, and on what terms, the need for supervision is manifest."⁴¹

In *Axcess Medical Clinic, Inc., v. Easterling*, a pain management clinic sued three members of the Mississippi State Board of Medical Licensure for shutting down the clinic for several months on the grounds that the physician-owner was "practicing pain management without the proper qualifications."⁴² The complaint alleged that the state board created "special education and certification requirements for a 'pain management medical practice' as arbitrarily defined by the board."⁴³ The court granted partial summary judgment with respect to due process and reputational injury in September 2015,⁴⁴ but no decision or settlement was reached on the antitrust claim.

Other cases have found sufficient supervision. In *Prime Healthcare Services-Monroe, LLC v. Indiana University Health Bloomington, Inc.*, Monroe Hospital accused Indiana University Health Bloomington of "unlawfully abusing and leveraging a municipally-granted monopoly in the provision of emergency medical transportation services in Monroe County."⁴⁵ Among other things, the defendant argued that it was immune from liability under the state action doctrine. The district court agreed, holding that under the second prong of the *North Carolina State Board* test, Indiana "actively supervises" IU Ambulance's delivery of patients

39. See Bill: SB 1107, TEX. LEGISLATURE ONLINE, <http://www.legis.state.tx.us/BillLookup/History.aspx?LegSess=85R&Bill=SB1107> (last visited May 18, 2017) (showing bill passed the Texas Senate on March 30, 2017, and the Texas House on May 12, 2017).

40. 178 So. 3d 71, 72 (Fla. Dist. Ct. App. 2015).

41. *Id.* at 77 (citing N.C. State Bd. of Dental Exam'rs v. FTC, 135 S. Ct. 1101, 1114 (2015)).

42. No. 3:14CV112 DPJ-FKB, 2015 WL 5642975, at *3 (S.D. Miss. Sept. 24, 2015).

43. Complaint, *Axcess Med. Clinic v. Miss. State Bd. of Med. Licensure*, No. 3:14CV112 DPJ-FKB, 2015 WL 5642975 (S.D. Miss. Apr. 24, 2015) (3:15cv307WHB-JCG).

44. *Axcess Med. Clinic*, 2015 WL 5642975, at *8.

45. No. 1:16-cv-00003-RLY-DKL, 2016 WL 6818956, at *1 (S.D. Ind. Sept. 30, 2016).

because through

its statutory scheme and . . . the enactment of the EMS Commission, [the state] . . . has developed comprehensive oversight of emergency medical services to protect consumer welfare. Therefore, permitting this lawsuit to go forward circumvents the process in favor of a federal forum. This is the very scenario the state-action doctrine was intended to prevent.⁴⁶

In *Murphy-Dubay v. Department of Licensing and Regulatory Affairs*, the plaintiff completed medical school in the Antilles but could not gain acceptance to a residency program in the United States.⁴⁷ He submitted an application on a form he created himself, seeking a “limited license” to practice medicine within the state of Michigan. He received a letter from the Michigan Board of Medicine stating that the board does not issue limited licenses to individuals upon request, and that these licenses are not for “someone whose education or training does not meet the requirements of licensure as a physician.”⁴⁸ The plaintiff filed an appeal seeking judicial review, and the Michigan Court of Appeals found that the policy complained of was “exempt from federal antitrust laws under the ‘state action’ doctrine because it is clearly articulated and affirmatively expressed as state policy and the policy is actively supervised by the state,” citing *North Carolina State Board*.⁴⁹

2. Nursing

In *Rodgers v. Louisiana Board of Nursing*, a nursing student claimed that the State of Louisiana Board of Nursing violated the Federal Sherman and Clayton Acts, by “restraining trade and commerce with respect to nursing education because the Board singularly relied upon an eighty percent passage rate to terminate” the plaintiff’s nursing program.⁵⁰ The district court granted the nursing board’s motion to dismiss the complaint, finding that it had no subject matter jurisdiction because the board was entitled to sovereign immunity.⁵¹ On appeal, the Fifth Circuit declined to import the second prong of the *Board of Dental Examiners* test from *Parker v. Brown* immunity to sovereign immunity.⁵²

46. *Id.* at *8.

47. 876 N.W.2d 598, 600 (Mich. Ct. App. 2015).

48. *Id.* at 601.

49. *Id.* at 607.

50. 665 F. App’x 326, 328 (5th Cir. 2016).

51. *Rodgers v. La. Bd. of Nursing*, No. 15-615-JJB-SCR, 2015 WL 9274930 (M.D. La. Dec. 18 2015).

52. *Rodgers*, 665 F. App’x at 330; see *supra* text accompanying note 8 (discussing *Parker*).

3. Chiropractors

In *Rivera-Nazario v. Corporacion del Fondo del Seguro del Estado*, a group of licensed chiropractors sued a public corporation created by the Puerto Rican legislature for the purpose of carrying out the Compensation System for Work-Related Accidents Act.⁵³ The chiropractors claimed the public corporation was violating the Sherman Act by excluding chiropractors from the workers compensation system. The court held that the corporation was exempt from complying with the active supervision requirement because it was a public subdivision of the State, with a public mission, and its board members were appointed by the Governor of Puerto Rico.⁵⁴ The court concluded that the corporation did “not pose the risk that market participants will use [it] to pursue private interest that the Court was concerned with in [*North Carolina State Board*].”⁵⁵

In *Petrie v. Virginia Board of Medicine*, a chiropractor sued the Virginia Board of Medicine for allegedly engaging in a conspiracy to exclude chiropractors from certain markets for medical services in violation of the Sherman Act.⁵⁶ The Fourth Circuit affirmed the lower court’s grant of summary judgment, concluding that the chiropractor failed to prove that the board’s actions constituted an unreasonable restraint of trade.⁵⁷ The court cited *North Carolina State Board* for the proposition that state government policy judgments are generally immune from attack under federal antitrust law.⁵⁸

4. Acupuncture

In *Henry v. North Carolina Acupuncture Licensing Board*, licensed physical therapists and their patients brought antitrust claims in federal court against the North Carolina Acupuncture Licensing Board after receiving cease-and-desist orders for providing “dry needling.”⁵⁹ The litigation was the continuation of a long-running dispute between physical therapists and acupuncturists over whether physical therapists were engaged in the practice of acupuncture by performing dry needling. The state attorney general had previously sided with the physical therapists, and a separate lawsuit filed by the acupuncture board against the state board of physical therapy examiners was dismissed on

53. No. 14-1533 (JAG), 2015 WL 9484490, at *1 (D.P.R. 2015).

54. *Id.* at *3.

55. *Id.* at *7.

56. 648 F. App’x 352, 354 (4th Cir. 2016).

57. *Id.* at 357.

58. *Id.* at 356.

59. No. 1:15-cv-00831, 2017 WL 401234, at *1 (M.D.N.C. 2015).

jurisdictional grounds. The antitrust suit is still pending.⁶⁰

5. Veterinarians

In *Robb v. Connecticut Board of Veterinary Medicine*, a veterinarian brought an antitrust action against the Connecticut Board of Veterinary Medicine, claiming that the board conspired to restrain trade through an agreement to remove from the Connecticut market for veterinary services any veterinarian who offered certain reduced dosages of the rabies vaccine to patient-animals.⁶¹ The district court found that the board, similar to the North Carolina Board, was “comprised of a majority of private practitioners” and was thus “capable of illegal concerted action.”⁶² But the court reasoned that the “capacity to conspire does not mean that every action taken by the Board satisfies [section 1 of the Sherman Act’s] contract, combination, or conspiracy requirement” and subsequently found that the plaintiff failed to plead “a single factual allegation affirmatively evincing the existence of an agreement amongst the Defendants.”⁶³

6. Dentists

In *Sensational Smiles, LLC v. Mullen*, a teeth-whitening service provider brought an action against the Commissioner of the Connecticut Department of Public Health, seeking relief against enforcement of a regulation that only allowed licensed dentists to use a light-emitting diode lamp to whiten teeth.⁶⁴ The district court held that a rational basis existed for the alleged discriminatory regulation.⁶⁵ In response to the plaintiff’s argument that the purpose of the restriction was to protect the monopoly on dental services enjoyed by licensed dentists, the United States Court of Appeals for the Second Circuit noted (citing *North Carolina State Board*) that “[t]his raises a question of growing importance and also permits us to emphasize that we do not decide . . . whether the regulation is valid under the antitrust laws.”⁶⁶

60. See Eric Kroh, *Acupuncture Antitrust Suit Goes Forward in North Carolina*, LAW360 (Jan. 31, 2017, 3:21 PM), <https://www.law360.com/articles/886552/acupuncture-antitrust-suit-goes-forward-in-north-carolina> (noting that a North Carolina federal judge denied a bid to dismiss a lawsuit against the North Carolina Acupuncture Licensing Board, dismissing the board’s arguments that the therapists had not adequately pled a conspiracy or antitrust injury).

61. 157 F. Supp. 3d 130, 132 (D. Conn. 2016).

62. *Id.* at 142–43.

63. *Id.* at 143, 147.

64. 793 F.3d 281, 283–84 (2d Cir. 2015), *cert. denied*, 136 S. Ct. 1160 (2016).

65. *Martinez v. Mullen*, 11 F. Supp. 3d 149, 169 (D. Conn. 2014).

66. *Martinez*, 793 F.3d at 286.

7. Other Contexts

Some of the farthest reaching consequences of the *North Carolina State Board* decision are outside the health care context. For example, prominent ride-sharing companies are using the ruling to challenge local restrictions on taxi services. In *Wallen v. St. Louis Metropolitan Taxicab Commission*, the plaintiffs sued the St. Louis Metropolitan Taxicab Commission, alleging the Commission's efforts to prohibit Uber from operating in St. Louis violated the Sherman Act.⁶⁷ After citing several paragraphs from *North Carolina State Board*, the district court concluded that the Commission was not entitled to state action immunity because its purpose was to regulate and oversee vehicles for hire to ensure public safety.⁶⁸ As such, "displacement of competition is not the logical result of the statutory framework," and "the state has not clearly articulated a policy of allowing anticompetitive conduct."⁶⁹

Similarly, LegalZoom, a national vendor that sells legal forms directly to consumers for their independent use, invoked *North Carolina State Board* to dispose of long-standing investigations or complaints by state bar associations. In October 2015, a consent decree was issued in *Legalzoom.com, Inc., v. North Carolina State Bar*,⁷⁰ under which the State Bar dropped its complaint against LegalZoom for the unauthorized practice of law, and LegalZoom dropped its antitrust claim against the State Bar. As a result, LegalZoom was able to register its prepaid legal service plans in North Carolina and sell its legal forms without further harassment by the State Bar.

III. RESTORATION, RESTRUCTURING, OR DISRUPTION?

What are the longer-term implications of *North Carolina State Board* for the conduct of professional licensing boards and therefore for the height of regulatory barriers to competition and innovation in health care? As baseball great Yogi Berra famously noted, "it is difficult to make predictions—especially about the future." But in general terms, the choices are basically: (i) restoring the status quo with assurances of good behavior; (ii) restructuring state boards to escape the application of the Supreme Court's standard; or (iii) truly disrupting how professional self-regulators do business.

Licensing boards think of themselves as gatekeepers and standard setters, upholding the traditions of their professions and protecting the

67. No. 4:15-cv-1432 HEA, 2016 WL 5846825, at *1 (E.D. Mo. Oct. 6, 2016).

68. *Id.* at *3–4.

69. *Id.* at *4.

70. No. 11 CVS 15111, 2015 WL 6441853, at *3 (N.C. Super. Ct. Oct. 22, 2015).

public from unsafe or unethical individuals. Depending on how the licensing board is constituted, some (or perhaps many) members will not have formal constituencies of economic actors to represent, and will instead seek to pursue the public interest as they see it. Boards do so by adopting general rules delineating permissible practices, and by disciplining specific licensees. Some (perhaps many) of these actions can be justified as the least restrictive means necessary to protect vulnerable buyers in a market beset by information gaps and asymmetries.

But some (again, perhaps many) board actions will also have overtly anticompetitive effects, in that they foreclose entire states as available markets for particular producers or particular products. Many members of professional licensing boards share biases based on commonalities of training and experience. Even if many of their decisions do not involve the egregious self-interest demonstrated in *North Carolina State Board*, there is still the risk they will act based on historically conditioned notions of how “their” profession should be behaving—as well as of the boundaries that mark their profession’s exclusive domain (i.e., their “turf”).

Furthermore, anticompetitive self-regulation is often challenging to disentangle from explicit state law. Health care is both subsidized and extensively regulated by state legislative and executive enactments that are fully immune from federal antitrust attack. Many of these laws, however, assume professional competence and ethics to achieve their objectives. The cumulative effect of embedding these unsupervised private processes within this seemingly comprehensive but inadequately specified regulatory framework is to worsen public policy-making inertia, and perpetuate conditions that are both anticompetitive and increasingly inconsistent with democratic preferences for access, quality, and efficiency.

For these reasons, we believe the *North Carolina State Board* decision has the potential to be a “disruptive innovation.” That term, coined by Harvard business school professor Clayton Christensen, is usually ascribed to new technologies and business models that fundamentally alter the competitive terrain.⁷¹ Disruptive innovations do not have to involve dramatic technological improvements or substantial gains in quality. Indeed, offering a “slimmed-down” product at a much lower price point can disrupt a business model built on “next year’s technology at next year’s prices.” *North Carolina State Board* has this disruptive

71. See generally CLAYTON M. CHRISTENSEN, *THE INNOVATOR’S PRESCRIPTION: A DISRUPTIVE SOLUTION FOR HEALTHCARE* (2008) (discussing a roadmap for innovation and reform for today’s broken health care system).

potential, because it may help remove long-standing obstacles to competition based on price, convenience, and reliability in health care.

We doubt that the six Supreme Court justices who made up the majority in *North Carolina State Board* had such lofty ambitions for their technical judgment as to the boundaries of the state action doctrine. Still, the opinion was surprisingly bold—turning on the substantive risk that state licensing boards were being co-opted by private market participants to serve anticompetitive purposes rather than based on formalities of board composition or procedural integrity. As such, the decision in *North Carolina State Board* provides new weaponry against health professions who use state power to further their self-interest, instead of serving the public. Certainly, the ruling should give licensing boards throughout the country significant pause before adopting ad hoc policies that disadvantage their competitors. More speculatively, the case has the potential to induce a general conversation (and perhaps uniform or model legislation) regarding the accountability of professional self-regulatory bodies to actual state government. Its impact could be comparable to a major revamping of Joint Commission standards for health care facilities—low in visibility, but dramatic in operational effect.

A. Initial Regulatory Responses

States can either defend the substantive merits of the decisions made by their licensing boards ex post, or they can take action ex ante to ensure the requirements of the state action doctrine are met. Governmental responses to the *North Carolina State Board* ruling were swift but hardly decisive. Within six months of the ruling, FTC staff released a detailed guidance document regarding both the need for “active supervision” and the forms it might take.⁷² The FTC’s analysis considers a range of situations, including circumstances where active market participants “control” board actions but lack a majority vote. Regardless of the specifics, when active market participants are in charge, the FTC believes “active supervision” is required to review both blanket rules and individual disciplinary actions.⁷³

Oklahoma and California also issued their own policies regarding the

72. FTC STAFF GUIDANCE ON ACTIVE SUPERVISION OF STATE REGULATORY BOARDS CONTROLLED BY MARKET PARTICIPANTS (Oct. 2015), https://www.ftc.gov/system/files/attachments/competition-policy-guidance/active_supervision_of_state_boards.pdf [hereinafter FTC GUIDANCE ON ACTIVE SUPERVISION].

73. Absent a pattern of selective enforcement, individual disciplinary actions are much less likely to be anticompetitive. *Id.*

North Carolina State Board decision. These pronouncements generally took the ruling seriously, discouraging licensing boards from intruding on competitive matters, and proposing new mechanisms for substantive review by formal state actors.

In Oklahoma, the governor issued an Executive Order requiring boards controlled by a majority of active market participants to submit all proposed licensure and prohibition actions, including major disciplinary actions, to the state attorney general for review.⁷⁴ Failure to comply with the attorney general's recommendation would result in dismissal for misconduct. A month later, the Oklahoma Attorney General issued guidance elaborating on the Executive Order.⁷⁵ Notably, the Executive Order does not apply to actions taken through formal rule making—where a state licensing board might also engage in anticompetitive conduct with far more extensive adverse consequences than would result from a single disciplinary action.

In California, the attorney general issued its own opinion on *North Carolina State Board*.⁷⁶ As in Oklahoma, the California Attorney General carved out rule making from actions requiring independent active supervision. But the California Attorney General opined that disciplinary actions did not require additional review because of existing procedural safeguards. It also argued that many actions of state boards are not “market-sensitive” and, in many instances, are procompetitive. Despite these caveats, the opinion points out that states can take various actions to comply with the holding in *North Carolina State Board*. The tactics include: (i) adopting legislation to change the composition of boards (which the attorney general did not favor); (ii) establishing a stand-alone office or one that is part of a larger agency such as the Department of Consumer Affairs to review board actions; (iii) modifying board powers to be advisory, with formal action reserved for a supervising agency; (iv) enacting laws expressly conferring antitrust immunity on boards, to the extent those laws would be upheld by the federal courts; and (v) providing indemnification for board members to ensure their continued willingness to serve. It remains to be seen whether California will take any of these steps given the permissive tone of the

74. Exec. Order No. 2015-33 (July 17, 2015), <https://www.sos.ok.gov/documents/executive/993.pdf>.

75. Letter from E. Scott Pruitt, Att’y Gen., to All Bds. & Comm’ns with Active Mkt. Participant Majorities (Aug. 17, 2015), <http://s3.amazonaws.com/content.newsok.com/documents/FINAL%20Letter%20to%20Agencies%2008212015.pdf>.

76. Office of the Att’y Gen., State of Cal., Formal Opinion No. 15-402, 98 Ops. Cal. Att’y Gen. 12 (Sept. 10, 2015), <https://media.nasba.org/files/2015/12/Dental-Case-CA-AG.pdf>.

attorney general's opinion.

In North Carolina itself, legislation was introduced that would require the state to actively supervise certain activities of the State Bar, "including the State Bar's actions taken against perceived competitors it claims are engaged in the 'unauthorized practice of law.'"⁷⁷ The bill would impose a requirement that before the State Bar can issue a demand to cease and desist the unauthorized practice of law, the "Attorney General shall review the substance and procedure of any decision . . . to ensure that the proposed action is consistent with State policy."⁷⁸ To date, the bill has not progressed beyond referral to the Senate Rules Committee.

B. Restoring the Status Quo

Some states may try to do as little as possible in response to *North Carolina State Board*. One strategy is to "lawyer" the Supreme Court's opinion into submission, by using every procedural and substantive argument to counter private lawsuits brought against state boards. This strategy will also involve strategically settling some disputes, to preserve the essence of self-regulatory authority even as specific decisions made under that authority are bargained away.

This seems to be how the TMB is currently defending its position in the *Teladoc, Inc. v. Texas Medical Board* litigation. Facing substantial opposition in its appeal to the Fifth Circuit of an adverse district court ruling on state action immunity, the State of Texas withdrew its petition, but pledged to defend its position on all other legal grounds.

Tactics of this sort allow antitrust litigation against state licensing boards to continue, but attempt to make the local legal environment inhospitable—especially to lawsuits brought by private plaintiffs rather than the federal enforcement agencies. As long as funding is available for an aggressive defense, and those serving on boards have assurances of indemnification, there are many novel, significant issues that courts will have to resolve before awarding victories to plaintiffs. For example, what standards for Sherman Act liability should courts apply to particular board actions? Which actions can be condemned after only a "quick look" rather than a full "rule of reason" inquiry? Do the same standards apply to actions that harm competition *within* the licensed profession

77. Complaint ¶ 3, *LegalZoom.Com, Inc. v. N.C. State Bar*, No. 1:15-CV-439, 2015 WL 34998877 (M.D.N.C. June 3, 2015) (citing S.B. 353, 2015 N.C. Sess. (Mar. 19, 2015)).

78. S.B. 353, 2015 N.C. Sess. (Mar. 19, 2015). See also *Senate Bill 353*, N.C. GEN. ASSEMBLY <http://www.ncga.state.nc.us/gascripts/BillLookUp/BillLookUp.pl?Session=2015&BillID=S353&votesToView=all> (last visited Apr. 17, 2017) (noting that the bill was referred to the Committee on Rules and Operations of the Senate on March 23, 2015 and subsequently died in committee).

versus actions that protect the licensed profession from external competition? What about actions that diminish competition in some ancillary activity but do not favor the economic interests of the profession? How does a plaintiff prove “antitrust injury”? Are individual disciplinary actions subject to review, absent evidence that they are part of a pattern to exclude certain classes of practitioners or types of practice? Which procompetitive benefits may be considered? How (if at all) should we measure the benefit of public confidence in the quality of licensed professionals, even if prices are higher and access (output) is lower because of licensure? To what degree do state sovereign immunity (as distinct from antitrust immunity) and the Eleventh Amendment constrain private actions seeking damages?⁷⁹

A related approach will be to attempt to obtain state legislative ratification of existing professional settlements while sidestepping the deeper competitive issues raised by *North Carolina State Board*. For example, as noted previously, the TMB cut a legislative deal during the pendency of the *Teladoc* litigation with the local telehealth industry, which would rewrite the challenged language of Rule 190.8 without wholly undercutting the board’s authority. Quick compromises of this sort may resolve the narrow issues in dispute, but they offer little assurance that barriers to competition will be lowered more generally. To the contrary, they potentially worsen anticompetitive harm by enabling existing stakeholders to buy off well-funded challengers while simultaneously using legislation to place the traditional self-regulatory architecture beyond the reach of antitrust law.

State legislatures may attempt to confer state action immunity on their existing professional boards by enacting blanket authorizations to depart from competitive norms—using COPAs as a template. These legislative pronouncements may or may not withstand review in federal court, but they send a signal to potential litigants that the full political power of the state will resist any challenge.

A final possibility, though one that is unlikely to improve competition in health care, is congressional intervention. The Supreme Court majority in *North Carolina State Board* did not seem concerned that its decision would trigger massive departures from licensing boards by professionals

79. While the FTC and the Department of Justice may sue states in federal court to enforce federal law, private parties may not. As a practical matter, then, private injunctive relief may depend on suing individual board members under *Ex parte Young*, and damage remedies may be unavailable even for egregiously anticompetitive conduct. See *Ex parte Young*, 209 U.S. 123, 155–56 (1908) (recognizing an exception to sovereign immunity in lawsuits against state officials of both state agencies and boards for declaratory or injunctive relief to stop ongoing violations of federal law).

concerned about their potential personal liability. But Congress might not feel equally reassured if pressured by the list of professional associations that filed amicus briefs in support of North Carolina. An analogous issue was central to an earlier case, *Patrick v. Burget*, in which the federal courts rejected a state action defense and upheld a multi-million dollar damage award to an Oregon surgeon who was denied hospital privileges by a credentialing committee controlled by his competitors (and former partners).⁸⁰ After the lower court decision was affirmed by the Supreme Court in 1988, there was widespread concern that physicians would refuse to participate in hospital-level peer review, which would result in the immediate collapse of the credentialing and privileges process.

Congress responded by enacting the Health Care Quality Improvement Act (“HCQIA”), which conferred antitrust immunity on physicians making bona fide staff privileges decisions as long as certain procedural requirements were satisfied.⁸¹ Congress essentially applied a “good faith plus due process” standard. A similar response to *North Carolina State Board* might be politically expedient, but it would almost certainly return licensing boards to “business as usual”—perpetuating many barriers to competitive entry and innovation as long as boards adequately document the basis for their decisions.

C. Restructuring Self-Regulatory Boards

In *North Carolina State Board*, the Supreme Court’s standard for triggering the active supervision requirement is whether a licensing board is “controlled” by “active market participants.”⁸² A straightforward adaptation to avoid liability is to restructure boards so that either control or market participation is reduced.

In its guidance document, FTC staff anticipated that states might be inclined to evade the requirement for active supervision with cosmetic changes that did not alter the underlying realities. Accordingly, FTC staff took a very expansive view of both market participation and of control. The guidance defines an “active market participant” as anyone who has a license issued by the board (including any license temporarily suspended or surrendered for the purpose of board service), or whose work is regulated by the board (whether or not the board member

80. *Patrick v. Burget*, 486 U.S. 94, 105 (1988).

81. Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, title IV, §401 (codified as amended at 42 U.S.C. § 11101 (2016)).

82. *N.C. State Bd. of Dental Exam’rs v. FTC*, 135 S. Ct. 1101, 1110 (2015).

performs the specific tasks associated with a challenged regulation).⁸³ Echoing the Supreme Court's opinion, FTC staff deemed the method of selecting board members irrelevant to "market participant" status.⁸⁴

North Carolina's dental board was unusual in that dentist members were elected by the state's dental practitioners, supporting an inference that they served their constituents' interests rather than the public interest. This fact could potentially limit the national impact of a high court ruling against it. At oral argument, however, when the FTC's lawyer cautiously began his presentation by focusing attention on board elections in North Carolina, Justice Elena Kagan immediately interrupted and expressed incredulity at his desire to base his case on such a small point.⁸⁵ Unsurprisingly, the Supreme Court's decision was not so limited.

With respect to control, capping active market participants at less than half the voting members would seem the simplest *ex ante* solution to *North Carolina State Board*. Although states can use this approach to comply with the letter of the law while evading its spirit (e.g., by appointing retired professionals or populating the remaining seats with individuals unlikely to challenge the judgments of the professionals on the board), this would still be a positive development given recent increases in the number of licensed professions—each with its own board. FTC staff also views "control" very expansively, and indicated it would consider a tradition of deference to professionals, their ability to take certain board actions without a majority, or even the necessity of obtaining the vote of one or more professionals to obtain a majority (i.e., veto power) as *de facto* "control" requiring active supervision.

Although the FTC staff did not highlight the point, it is important to acknowledge that the current structure of state licensure, which depends on self-regulatory boundaries dividing professions, itself has anticompetitive consequences. National organizations representing state boards of medicine, nursing, and pharmacy have recognized the dysfunctions that result from this siloed approach, and therefore created a Tri-Regulator Collaborative to share information and ultimately remake many licensing and disciplinary functions using an interprofessional model.⁸⁶ It is interesting to consider how a court hearing an antitrust suit

83. FTC GUIDANCE ON ACTIVE SUPERVISION, *supra* note 72, at 7.

84. *Id.*

85. Transcript of Oral Argument at 28, *N.C. State Bd. of Dental Exam'rs*, 135 S. Ct. 1101 (No. 13-534), https://www.supremecourt.gov/oral_arguments/argument_transcripts/13-534_8nj9.pdf.

86. HUMAYUN J. CHAUDHRY ET AL., TRI-REGULATOR COLLABORATIVE POSITION STATEMENT ON INTERPROFESSIONAL, TEAM-BASED PATIENT CARE (2014), https://www.ncsbn.org/Team-Based_Care.pdf (describing the joint publication of the Federation of State Medical Boards, National Association of Boards of Pharmacy, and National Council of State Boards of Nursing).

might deal with a licensing board based on an interprofessional model where no single group constituted a majority, with or without substantial membership from consumers and other laypeople. Should the court presume that the licensed professionals on the board will engage in log-rolling, thereby maintaining the status quo, or does the presence of multiple professionals cut against that assessment?

Alternatively, a state could create an umbrella board with oversight responsibility for the decisions of individual professional boards. The umbrella board would both insulate the subsidiary boards from suit and avoid the overtly parochial self-interest that might otherwise prevail in a subsidiary board.

D. Putting Meaningful Active Supervision in Place

There are many paths a state can follow in satisfying the requirement for active supervision. In *North Carolina State Board*, the Supreme Court stated only that the state supervising authority “must review the substance of the anticompetitive decision[;] . . . must have the power to veto or modify particular decisions to ensure they accord with state policy; and . . . may not itself be an active market participant.”⁸⁷ The lodestar for the Court is political accountability at the state level. Open questions include the locus and timing of review and approval, the degree of responsiveness to public complaints or comments, the basis and record for decisions, and the degree to which board actions may be aggregated and periodically reviewed and approved in groups.

1. National Coordination

States may be tempted to craft idiosyncratic approaches to supervising health professional boards based on their constitutional frameworks, political preferences, governance traditions, and administrative procedure acts. It is likely that such solutions will prove harder than expected to develop and implement—in part because most medical boards are treated with great deference (and, as a result, usually protect their licensees more effectively than they protect the public), and in part because too much variation may prove problematic for national organizations, such as the Federation of State Medical Boards (“FSMB”) and the American Medical Association.

For these reasons, coordinated approaches to active supervision seem desirable. Because the aggregate national investment in health care is so great, and because most of those funds are redistributed from state to state through either public or private insurance, there are many groups and

87. *N.C. State Bd. Dental Exam’rs*, 135 S. Ct. at 1116–17 (internal citations omitted).

organizations available to develop national “best practices” for active supervision or a uniform state law. Possible convening organizations include the FSMB, the National Academy for State Health Policy, the National Governors Association, the Administrative Conference of the United States, and the National Association of State Attorneys General. It is also conceivable, though less likely, that congressional intervention might result in legislation containing federal “safe harbors” for modes of state supervision that further competition rather than merely reinforce the status quo.

2. Judicial Review

Judicial review is problematic as active supervision, although the Supreme Court has not definitively stated that it is insufficient. Judicial review is almost always reactive rather than routine; tends to focus on procedural aspects of administrative decisions; and even when oriented toward substance applies deferential standards based on rationality or nonarbitrariness. Obviously that would not invalidate the majority of licensing board actions—no matter how self-interested they actually are.

Courts would also struggle to evaluate the evidentiary basis for decisions. Unlike most administrative agencies, medical boards are expert, but not fully accountable, decision makers. Physicians serving on medical boards tend to be regarded as independent authorities on appropriate practice rather than as skilled analysts of objective scientific evidence. As a result, the deference that courts typically owe to an agency under state administrative law is compounded by the traditional deference given to physicians.

3. Legislative Review

Routine legislative review would be difficult in most, if not all, states. The purpose of administrative delegation is to facilitate expert, timely resolution of issues that are either not sufficiently important or are too politically contentious for a state legislature to decide itself. Periodic legislative ratification might prove inadequate as active supervision because it is untimely and likely to be superficial.

One advantage of state legislative review is that it would subject a much larger percentage of anticompetitive regulation affecting health care to bona fide political accountability – which after all is the core purpose of the active supervision requirement. But if legislators continue historical patterns of hyperdeference to physician experience as communicated through licensing boards, the result will be merely the “gauzy cloak of state involvement” criticized by the Supreme Court in

*California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*⁸⁸ That shouldn't fly in the federal courts—and it won't.

4. Administrative or Attorney General Oversight

As our discussion of Oklahoma suggests, in many instances supervision can be performed by an administrative office of state government. The underlying concept of that approach is to transition health professional boards (e.g., medicine, nursing, pharmacy, etc.) from a “statutory self-regulation” model to a “supervised self-regulation” model.⁸⁹ The former model is based on a general legislative delegation of authority, while the latter places each board under the direct control of a named state agency such as a department of health, a consumer protection bureau, or the state attorney general's office.

The regulatory supervisor would subject each board's actions to structured review and approval on a routine basis, and often would be able to coordinate activities and mediate disputes among boards. Depending on the board and the action it is taking, each board's initial degree of autonomy could vary. Actions with substantial risk of anticompetitive consequences might be subjected to an FDA Advisory Committee approach, in which the agency, and not the board, issues the operative decisions. Actions with less risk might more resemble the relationship among the Joint Commission, the Centers for Medicare and Medicaid Services, and state Medicaid agencies determining which hospitals may serve Medicare and Medicaid patients.

FTC staff guidance contemplates executive agency review of this sort, including independently gathering information from the public; weighing the substance of the board's proposed action; and issuing a written opinion accepting, modifying, or rejecting it.⁹⁰ Although this represents the FTC staff's wish list and not the state of the law, facts will matter greatly in resolving disputes that arise under *North Carolina State Board*. Evidence regarding the accuracy, comprehensiveness, and persuasiveness of challenged decisions therefore is likely to be a recurrent need. Administrative standards will depart from the subjective, experiential fashion in which state licensing boards have historically operated—sometimes overturning hearing officers who had assembled

88. *Cal. Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 106 (1980).

89. Margot Priest, *The Privatization of Regulation: Five Models of Self-Regulation*, 29 OTTAWA L. REV. 233, 239–44 (1997–1998) (classifying self-regulatory models).

90. FTC GUIDANCE ON ACTIVE SUPERVISION, *supra* note 72; *see also* Debbie Feinstein & Geoffrey Green, Bureau of Competition, Fed. Trade Comm'n, *The When and What of Active Supervision*, FED. TRADE COMMISSION (Oct. 14, 2015, 12:28 PM), <https://www.ftc.gov/news-events/blogs/competition-matters/2015/10/when-what-active-supervision>.

impressive amounts of more objective evidence supporting contrary conclusions. A beneficial consequence of exposing licensing board actions to antitrust scrutiny is that evidence refuting competitive harm or demonstrating offsetting competitive benefits should become more rigorous.

CONCLUSION

When it comes to health care, the government wears multiple hats—and often behaves as if it has multiple personalities. As a payor, the government prioritizes access to care for its beneficiaries at a predictable cost to itself. As a regulator, the government prioritizes a minimum level of quality, enforced through restrictions on entry and occasional sanctioning of outliers. When exercising these politically controversial functions, the government very often defers to and empowers the medical profession to set standards for patient care, professional independence, and insurance coverage. As competition advocate and antitrust enforcer, however, the government prioritizes active markets with fluid entry, continuous innovation, and consumer sovereignty—goals that are supposedly agnostic to the products sold and the sellers thereof. When all three perspectives must be considered—let alone harmonized—the degree of difficulty becomes immense.

As a doctrinal matter, professions have been subject to the antitrust laws for the last forty years. Nonetheless, market competition has been unable to secure for health care consumers the benefits of fairly priced, readily accessible, reliable, and innovative products that are common in other industries. In our view, the explanation is that competition policy in health care is one part antitrust enforcement, but several parts regulation and several parts subsidy. Antitrust enforcers have largely failed to navigate the narrow channel between the Scylla of ignoring the government's responsibilities as a payor and regulator, and the Charybdis of acquiescing to overtly anticompetitive behavior as long as it is covered by a gossamer-thin assertion of state action.

North Carolina State Board has the potential to catalyze the health care system's transition to a new regulatory-competitive equilibrium that is less wasteful of resources and more hospitable to new entry and innovation. It remains to be seen if the decision will have a small or large effect on competition in health care. The best case scenario is that active supervision will serve as a partial "reset" button for competition in health care, reducing costs of production and enabling new methods of service delivery that improve value for consumers. The worst case scenario is that nothing much will change, apart from some "papering of the file" to satisfy the active supervision requirement.

Physician control of the health care marketplace is enshrined in explicit law and in the long traditions of professional self-regulation. As a result, *North Carolina State Board* may or may not signal a sea change in the structure and performance of the health care system. But, at the very least, the Supreme Court's requirement of active supervision demands that when state medical boards are called to account for anticompetitive decisions, their defense must consist of "something more than 'we're doctors, trust us.'"⁹¹

91. William M. Sage, *Competitive Harm from State Licensing Boards: First North Carolina Dentists, Now Texas Physicians?*, HEALTH AFF. (May 27 2015), <http://healthaffairs.org/blog/2015/05/27/competitive-harm-from-state-licensing-boards-first-north-carolina-dentists-now-texas-physicians/> (quoting the federal district judge hearing the *Teladoc, Inc. v. Texas Medical Board* antitrust case against the TMB's attempt to limit telephonic physician prescribing).