No. 20-3072

In the
United States Court of Appeals
for the Seventh Circuit

ASSOCIATION OF AMERICAN PHYSICIANS
& SURGEONS, INCORPORATED,

Plaintiff-Appellant,

v.

AMERICAN BOARD OF MEDICAL SPECIALTIES,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division, No. 1:14-cv-02705.
The Honorable **Martha M. Pacold**, Judge Presiding.

BRIEF AND APPENDIX OF PLAINTIFF-APPELLANT ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC.

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Appellate Court No: 20-3072

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Plaintiff-Appellant Association of American Physicians & Surgeons, Inc.

(2) The names of all law firms whose partners or associates have appeared for the party in the case (including proceedings in the district court or before an administrative agency) or are expected to appear for the party in this court:

Andrew Schlafly, Esq., and an attorney at Bravos & DiCola located in Wheaton, Illinois

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Attorney's Signature: s/ Andrew L. Schlafly Date: November 12, 2020

Attorney's Printed Name: Andrew L. Schlafly

Please indicate if you are *Counsel of Record* for the above listed parties pursuant to Circuit Rule 3(d). **Yes** ☑ **No** ☐

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JURISDICTIONAL STATEMENT

The district court had jurisdiction as a civil action arising under the laws of the United States, namely Section 16 of the Clayton Act, 15 U.S.C. § 26, to secure equitable relief against continuing violations by Defendant-Appellee American Board of Medical Specialties ("ABMS") of Section 1 of the Sherman Act, 15 U.S.C. § 1, and under Section 4 of the Clayton Act, 15 U.S.C. § 15, to recover treble the amount of damages incurred due to ABMS's violations. (Amended Complaint ("Am. Compl."), Dkt. #49, ¶ 9)

The district court had supplemental jurisdiction under 28 U.S.C. § 1367 over the additional claim by Plaintiff-Appellant Association of American Physicians & Surgeons, Inc. ("AAPS") for deceptive trade practices, under 815 Ill. Comp. Stat. 510/2. (*Id.* ¶ 10) The district court further had subject matter jurisdiction over this claim pursuant to 28 U.S.C. § 1332, because there is diversity of citizenship of the parties and the amount in controversy exceeds $75,000. (*Id.*) AAPS is incorporated in Indiana and has its principle place of business in Arizona, while ABMS is incorporated in Illinois and has its principle place of business there. (*Id.* ¶¶ 7-8)

This appeal is taken, by a timely Notice of Appeal filed on October 21, 2020 (Dkt. #98), from the final judgment of the U.S. District Court for the Northern District of Illinois entered on September 22, 2020, by the Honorable Martha M. Pacold. (A-1 and A-17, Dkt. ##96-97) The United States Court of Appeals has jurisdiction to decide this case pursuant to 28 U.S.C. § 1291.

STATEMENT OF ISSUES

The issues presented are:

1. Whether a district court should dismiss a complaint based on its own perception of plausibility, uninformed by any factual development, rather than accepting well-pleaded allegations as true and construing inferences in favor of the plaintiff.

2. Whether specific evidence must be alleged to comply with the pleading standard established by *Ashcroft v. Iqbal*, 556 U.S. 662 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544 (2007).

3. Whether it was an error for the district court to dismiss the claim for deceptive trade practices when an entity misleadingly disparages others for not meeting "requirements" of a "Board" which is, in fact, a private entity having no legal authority to impose any "requirements" or act like a state medical board.

STATEMENT OF THE CASE

AAPS brought this action to end antitrust law violations and deceptive trade practices by Defendant ABMS concerning its controversial "maintenance of certification" (MOC) product, which reduces the availability of physicians to patients. (Am. Compl., Dkt. #49 ¶ 1) AAPS alleged that ABMS has conspired with specialty board organizations, health insurers, and hospitals to compel physicians[1] to purchase and spend unjustified

[1] The term "physicians" in this case, as alleged in the Amended Complaint, refers to those holding an "M.D." degree, which is the large category of medical professionals whom Defendant ABMS targets.

time and money on its proprietary ABMS Maintenance of Certification®. (*Id.*) Collusion by ABMS to restrain trade has excluded physicians from the relevant market who do not purchase ABMS's product or who do purchase it but are deemed not to have attained a passing grade. (*Id.*) ABMS engages in a money-making scheme that reduces the output of hospital-based and insurance in-network physicians in violation of Section 1 of the Sherman Act. (*Id.*)

AAPS further alleges that ABMS engages in deceptive trade practices, as ABMS "disparages the goods, services, or business of another by false or misleading representation of fact," in violation of 815 Ill. Comp. Stat. 510/2(a)(8). (*Id.* ¶ 2) ABMS misleadingly denigrates physicians who decline to participate in its MOC program, by falsely implying that such physicians are of quality inferior to those who do purchase ABMS's product at substantial expense in time and financial cost. (*Id.*)

ABMS has no governmental or academic legitimacy, and yet falsely implies that it does. (*Id.* ¶ 3) ABMS also falsely implies that hospitals and insurance plans are incorporating certification requirements based on quality, when in fact ABMS itself covertly colludes with hospitals and insurers to impose its proprietary product. (*Id.*) ABMS conceals from the public how it arbitrarily exempts more entrenched older physicians from purchasing and participating in its program, which undermines ABMS's pretensions of legitimacy. (*Id.*)

Defendant's imposition of its Maintenance of Certification® is so unjustified and

pernicious that multiple state legislatures have taken the extraordinary step of prohibiting the imposition of requirements based on it. (*Id.* ¶ 4) Additional state legislatures are considering new bills to prohibit government, health insurers, and hospitals from requiring Defendant ABMS's Maintenance of Certification®. (*Id.*) Such state legislation does not, however, enjoin Defendant's restraint of trade and deceptive trade practices, or compensate the victims of it. (*Id.*)

As summarized in a letter by Texas Medical Association President Carlos J. Cardenas, M.D., which was published in the prestigious *Journal of the American Medical Ass'n* (JAMA):

> [Board certifying societies] are … profit-driven organizations beholden to their own financial interests. The MOC process is too expensive, requires physicians to take too much time away from their patients and families, and, most importantly, lacks sufficient research to document the benefits to patient care. Many physicians say the information studied and tested has little applicability to their day-to-day practice.

JAMA, 2018:319(1), 83-84 (multiple supporting references omitted). *See also id.* at 84 (Washington University School of Medicine Professor of Surgery Bradley D. Freeman, M.D., explaining that MOC is an impediment to "enhanc[ing] both quality of care and professional satisfaction") (Dkt. #49, ¶ 5).

A. Factual Background

1. The Parties.

Plaintiff AAPS was founded in 1943 and is a nonprofit membership organization of physicians in virtually all specialties. (*Id.* ¶ 7) Incorporated under the laws of Indiana,

AAPS membership includes physicians practicing in Illinois, and members of AAPS have been harmed by the ongoing antitrust violations by ABMS and by its deceptive trade practices. (*Id.*) As to Defendant ABMS, it is a nonprofit entity incorporated in Illinois, where its headquarters are located in Chicago at 222 North LaSalle Street, Suite 1500. (*Id.* ¶ 8)

ABMS and 24 separate corporations have agreed to impose on physicians a recertification program named the ABMS Maintenance of Certification® (also known as "ABMS MOC®"). (*Id.* ¶ 13) The 24 corporations, known as the "Specialty Boards," are specifically listed in the Amended Complaint. (*Id.* ¶ 14)

2. The Restraint of Trade by ABMS.

ABMS and the Specialty Boards have conspired to impose the ABMS MOC® program against all physicians having an "M.D." degree, with arbitrary exemptions for older physicians. (*Id.* ¶ 15) In addition, ABMS has conspired with health insurers and hospitals to require physicians to purchase the ABMS MOC® product as a condition of being in health plan networks or having medical staff privileges, respectively. (*Id.* ¶ 16) The collusion by ABMS with health insurers and hospitals constitutes an illegal agreement in restraint of a trade and an illegal "tying" of products and services under the Sherman Act. (*Id.* ¶ 17)

Specifically, ABMS has conspired with health insurers having market power, in order to compel physicians to purchase the ABMS MOC® product. (*Id.* ¶ 18) ABMS

publicly admits that it encouraged and obtained a commitment by the Blue Cross and Blue Shield Association ("BCBSA") to require physicians to purchase and participate in ABMS MOC® as a condition of physicians being in-network with health insurance plans. (*Id.* ¶ 19) This conspiracy between ABMS and BCBSA has proximately caused Blue Cross and Blue Shield-affiliated health plans in multiple states impose a requirement that physicians purchase and participate in ABMS MOC® as a condition of participating in their health insurance networks. (*Id.* ¶ 20) For example, Blue Cross and Blue Shield of Massachusetts requires certification with ABMS or its Specialty Boards as a condition of physicians being allowed to participate in its health plan network. (*Id.* ¶ 21)

Similarly, in Pennsylvania, Independence Blue Cross now requires that physicians be board certified through Defendant ABMS, which also applies to some or all of the many subsidiaries of Independence Blue Cross, including Independence Hospital Indemnity Plan, Keystone Health Plan East, QCC Insurance Company, and Highmark Blue Shield. (*Id.* ¶ 22) In addition, Defendant ABMS has colluded with other groups to induce health insurers to "use Board Certification by an ABMS Member Board as an essential tool to assess physician credentials within a given medical specialty." (*Id.* ¶ 23) Most health insurers, particularly in metropolitan areas, require that physicians purchase and comply with Defendant's ABMS MOC® product as a condition of being in-network with the insurer. (*Id.* ¶ 24)

ABMS has also sought and obtained agreement by hospitals having market power,

in order to enforce Defendant's ABMS MOC® product as a condition of holding medical staff privileges. (*Id.* ¶ 25) The American Hospital Association ("AHA"), a trade association representing nearly all hospitals in the United States, is an associate member of Defendant ABMS and agrees with it to impose ABMS MOC® on physicians. (*Id.* ¶ 26) In Defendant ABMS's "Portfolio Program™," ABMS explains its campaign to induce hospitals to impose the ABMS MOC® product as a condition of holding medical staff privileges. (*Id.* ¶ 27) Specifically, Defendant ABMS requires of hospitals as a condition of joining its Portfolio Program™ that the hospital agree and represent that it has "a willingness to commit necessary resources and consider MOC a requirement for medical staff privileges for eligible physicians." (*Id.* ¶ 28, citation omitted) ABMS induces agreement by hospitals and other organizations to its foregoing condition by expressly stipulating that those which "***cannot confidently answer 'yes' to all of the items … are unlikely to be approved for participation***." (*Id.* ¶ 29, emphasis in the ABMS original, citation omitted) Several hospitals are listed as "sponsors" of the ABMS Portfolio Program™, including Palmetto Health in Columbia, South Carolina. (*Id.* ¶ 30) Approximately 80% of hospitals now require certification by ABMS as a condition for physicians to be on the medical staff, and outside of Texas and Oklahoma nearly all of those hospitals now require that physicians purchase and spend enormous time on the proprietary product of ABMS MOC® in order to have medical staff privileges. (*Id.* ¶ 31)

ABMS, the Specialty Boards, health insurers, and hospitals, by agreeing to impose

burdensome recertification through ABMS MOC® as a condition of being in insurance networks and maintaining hospital medical staff privileges, reduce the output of medical services and increase the prices to consumers in the relevant market. (*Id.* ¶ 32) For example, ABMS's foregoing agreements and actions caused the unjustified exclusion of a physician member ("J.E.") of Plaintiff AAPS from the medical staff at Somerset Medical Center ("SMC"), a hospital located in Somerville, New Jersey. (*Id.* ¶ 33) Physician J.E. had been on the SMC medical staff to treat patients there for twenty-nine (29) years. (*Id.* ¶ 34) In 2011, SMC refused to allow J.E. to continue to remain on its medical staff unless he purchased and complied with ABMS MOC®. (*Id.* ¶ 35) Many physicians, such as AAPS physician member J.E., choose not to purchase and participate in ABMS MOC® because it would impinge on their time to spend caring for their patients, including their charity care. (*Id.* ¶ 36) AAPS member J.E. had been fully certified in good standing with the predecessor to one of the 24 Specialty Boards, the American Board of Family Medicine ("ABFM"). (*Id.* ¶ 37) Defendant ABMS has agreed with ABFM and hospitals to impose the extensive burdens of ABMS MOC® on J.E. and other physicians. (*Id.* ¶ 38) Effective June 24, 2011, SMC excluded J.E. from its medical staff, due to Defendant ABMS's activities and agreements to impose its ABMS MOC® product. (*Id.* ¶ 39)

Like many other AAPS physician members, J.E. spends a substantial percentage of his time providing charity care to patients who would not otherwise have access to medical care. (*Id.* ¶ 40) Yet because of Defendant ABMS's actions, patients are denied

the benefit of being evaluated and treated by J.E. when taken by emergency to SMC. (*Id.* ¶ 41) Studies show that physicians typically lack enough time to spend any more than about 7 or 8 minutes on average seeing each patient. (*Id.* ¶ 42) In addition, physicians are spending less time providing charity care because they have diminishing time to do so. (*Id.* ¶ 43) The lifespan and professional career of a physician are shorter than that of most other professionals. (*Id.* ¶ 44) Physicians spend more time in training than most other professionals. (*Id.* ¶ 45) Despite this, the additional burdens on physicians' time imposed by the ABMS MOC® product is substantial, often exceeding 100 hours per year. (*Id.* ¶ 46) For the average physician in clinical practice, that time burden takes the physician's availability away from more than 700 patient-visits per year. (*Id.* ¶ 47) In general, the more patients that a particular physician sees and treats, the greater the interference in his practice that is imposed by ABMS MOC®. (*Id.* ¶ 48) J.E. manages and works in a standalone medical charity clinic for a substantial part of each week. (*Id.* ¶ 49) Requiring J.E. to purchase and spend hundreds of hours on ABMS MOC® would result in an hour-for-hour reduction in his availability to provide medical care to his many charity patients, who have far surpassed 30,000 patient visits in total number. (*Id.* ¶ 50) Patients of J.E. are typically impoverished and lack any alternate means of obtaining comparable medical care. (*Id.* ¶ 51)

J.E. continued to serve his non-hospitalized charity patients rather than comply with the immense burdens of recertification demanded by Defendant's agreements to

implement ABMS MOC®. (*Id.* ¶ 52) Defendant ABMS has entered into agreements with many of the Specialty Boards to impose even greater burdens of time and expense on physicians; as of April 6, 2013, Defendant "ABMS is requiring more frequent participation in MOC of all board certified physicians." (*Id.* ¶ 53, quoting an email sent to physicians by the American Board of Internal Medicine ("ABIM") on or about April 6, 2013) Defendant ABMS and its Specialty Boards fail a substantial percentage of physicians who do purchase and participate in ABMS MOC®, without even providing them with an opportunity to review and challenge the questions-and-answer choices that they purportedly responded to incorrectly. (*Id.* ¶ 54) It is contrary to public policy for ABMS, as a private entity lacking in public accountability and transparency, to impose its own proprietary product as a condition for patients to have access to physicians in insurance networks and at hospitals. (*Id.* ¶ 55) Defendant's ABMS MOC® program imposes far greater burdens than any analogous program in any other profession, and surveys demonstrate that an overwhelming majority of physicians – perhaps more than 90% – feel that Defendant's program is unjustified. (*Id.* ¶ 56) There is no proven benefit to patient care from Defendant's ABMS MOC® product. (*Id.* ¶ 57)

Illustrating that ABMS MOC® is a money-making scheme unrelated to quality of care, at least one Specialty Board has offered ten years of recertification in exchange for a substantial cash payment, in lieu of an examination. (*Id.* ¶ 58) Every State has one or more official medical boards authorized by law and accountable to the public, to

determine the fitness of physicians to practice medicine, and yet none of them require purchase of or participation in ABMS MOC® as a condition of licensure. (*Id.* ¶ 59) Several States, including Texas and Oklahoma, have even enacted laws prohibiting imposition of ABMS MOC® as requirements of physicians in various contexts. (*Id.* ¶ 60) Academic physicians have been critical of the lack of benefits from maintenance of certification, observing that alternative uses of physicians' time are superior means of promoting quality of care. (*Id.* ¶ 61) The lack of any genuine value of ABMS MOC® as a measure of professional skill or competence is demonstrated by how ABMS itself selected and appointed as its new President/CEO in 2012 someone who chose not to purchase and complete ABMS MOC®, and instead took advantage of an arbitrary exemption not available to most physicians. (*Id.* ¶ 62)

There are no meaningful safeguards in the ABMS MOC® product against unlawful discrimination in how it creates obstacles to the practice of medicine. (*Id.* ¶ 63) Upon information and belief, the tests imposed pursuant to the ABMS MOC® program discriminate against women and minorities, failing a disproportionate percentage of members of those groups. (*Id.* ¶ 64) Unlike the SAT and other nationwide examinations, Defendant ABMS does not release the results of its MOC examinations based on race and gender, in order to mislead the public into believing that the MOC examinations are fair and unbiased. (*Id.* ¶ 65) Defendant's ABMS MOC® product further discriminates against physicians in small, rural practices who see many patients, because they lack the extra

time and support staff to allow diversion of the physicians' time for compliance with the burdens of Defendant's MOC. (*Id.* ¶ 66)

As to the relevant service market, it consists of medical care provided by physicians who are subject to MOC, and who are either in-network, or seek to be in-network, with health insurers, or treat or seek to treat hospitalized patients. (*Id.* ¶ 67) The relevant geographic market is nationwide except for States that have generally prohibited MOC requirements, as Texas has. (*Id.* ¶ 68)

ABMS and its Specialty Boards have a substantial pecuniary interest in requiring physicians to purchase their products in the ABMS MOC® program. (*Id.* ¶ 69) Publicly available IRS Forms 990 set forth the self-enrichment by executives at the ostensibly non-profit Defendant ABMS and the Specialty Boards, which results in large part from their restraint of trade and deceptive trade practices:[2]

Executive	"Nonprofit" Annual Compensation (including related organizations)
ABMS President (2015)	$774,054.00
ABFM President (2015)	$1,105,148.00
ABIM President (2015)	$849,483.00

ABMS Form 990 (2015), Part VII, Section A attachment, p. 1; ABFM Form 990 (2015), Part

[2] IRS Form 990s by nonprofit organizations are readily available to the public on the internet at multiple websites, including http:www.guidestar.org and http://foundationcenter.org/find-funding/990-finder .

VII, Section A, p. 2; ABIM Form 990 (2015), Part VII, Section A attachment, p. 1. (*Id.* ¶ 70) Defendant ABMS has acted with a pecuniary interest in persuading and coercing health insurers and hospitals to impose ABMS MOC. (*Id.* ¶ 71)

3. The Deceptive Trade Practices by ABMS.

ABMS falsely implies that its product has governmental or academic legitimacy, when it does not, and ABMS conceals how it arbitrarily exempts older physicians from purchasing and participating in its program. (*Id.* ¶ 3) ABMS misleadingly implies that hospitals and insurance plans are incorporating certification requirements based on quality, when in fact ABMS itself covertly colludes with hospitals and insurers to impose its proprietary product. (*Id.*)

In clever but deceptive ways, Defendant publicly disparages physicians who decline to purchase the ABMS MOC® product. (*Id.* ¶ 98) Disparagement in public of a physician is particularly harmful to his career, because health insurers, hospitals, and patients tend to avoid physicians who have any blemish on their reputation. (*Id.* ¶ 99) Despite how there are no statutory or regulatory "requirements" to use ABMS MOC®, ABMS misleadingly disparages physicians who decline to purchase the ABMS MOC® product, by ABMS making statements like "Not Meeting MOC Requirements." (*Id.* ¶ 100) ABMS invites the public to search on its website for individual physicians to check if they have complied with its ABMS MOC® product, while falsely implying that physicians who decline to purchase and comply with Defendant's product are somehow

less competent. (*Id.* ¶ 101) Defendant's use of the word "Requirements" and similar terms misleads the public by obscuring that the proprietary ABMS MOC® product is, in fact, lacking in any legal, governmental, or academic requirement or oversight. (*Id.* ¶ 102) Defendant's characterizations are as misleading as if Amazon.com posted on the internet the names of customers who declined to purchase its "Amazon Prime" product and described them as "Not Meeting Amazon Prime Requirements," or if Apple publicly posted the names of customers who declined to purchase its latest iPhone as "Not Meeting iPhone Requirements." (*Id.* ¶ 103)

Defendant ABMS also deceptively promotes its ABMS MOC® product as though health insurers and hospitals are independently requiring it of physicians, when in fact ABMS itself covertly arranges for health insurers and hospitals to impose ABMS's product on physicians. (*Id.* ¶ 104) ABMS further deceptively implements and promotes its ABMS MOC® product by concealing how it discriminates against women and minorities, thereby misleading the public to think that it is a fair and impartial certification of quality. (*Id.* ¶ 105) Several states, including Texas and Oklahoma, have passed laws to limit requiring use of ABMS MOC®, but ABMS fails to disclose this in response to inquiries from patients or entities. (*Id.* ¶ 106) In addition, ABMS withholds from the public that it arbitrarily exempts many thousands of physicians from its "MOC Requirements," and deceptively conceals how arbitrary its exemptions are, while disparaging physicians who are not considered by Defendant to be exempt. (*Id.* ¶ 107)

Defendant's ABMS MOC® program is designed primarily to increase the revenue to ABMS and its Specialty Boards, and increase the compensation to their executives, rather than engage in any genuine attempt to improve quality of care for patients. (*Id.* ¶ 108) Many of the questions asked of physicians as part of Defendant's ABMS MOC®, for which physicians must provide Defendant's preferred answer choices in order to be recertified, have no relevance to the quality of care that the physician provides, and there is no meaningful academic or governmental oversight, public accountability or transparency as to whether the answer choices considered "correct" by Defendant are actually the best answers. (*Id.* ¶ 109)

ABMS misleadingly emphasizes the term "Board" to falsely imply that it has some authority akin to an official state medical board, when in fact ABMS and its co-conspirators lack any official legitimacy. (*Id.* ¶ 110) ABMS has engaged in deceptive trade practices by its misleading conduct and by falsely pretending that its ABMS MOC® product accurately measures the medical skills and competence of practicing physicians. (*Id.* ¶ 111) ABMS willfully engages in its foregoing deceptive trade practices. (*Id.* ¶ 115)

B. Relevant Procedural History

AAPS filed this lawsuit on April 23, 2013, in New Jersey. (Dkt. #1) Transfer of this lawsuit to the Northern District of Illinois, at the request of ABMS, was ordered on April 2, 2014. (Dkt. #23)

On December 13, 2017, the district court below dismissed without prejudice the original Complaint, which asserted claims for restraint of trade in violation of Section 1 of the Sherman Act and for negligent misrepresentation. (Dkt. #48) The district court expressly declined to reach the issue of the alleged conspiracy, and instead dismissed the Sherman Act claim entirely on the basis of finding that there was not an unlawful restraint on competition. (*Id.*)

On January 16, 2018, AAPS timely filed its Amended Complaint which is the subject of this appeal. (Dkt. #49) AAPS asserted two causes of action: Count I for violation of Section 1 of the Sherman Act, and Count II for deceptive trade practices under Illinois law, 815 Ill. Comp. Stat. 510/2. AAPS, in a class action, sought compensatory, declaratory and injunctive relief against ABMS. (*Id.*) On March 6, 2018, ABMS moved to dismiss (Dkt. #51), with a supporting memorandum (Dkt. #52). The district court dismissed the Amended Complaint with prejudice on September 22, 2020 (Dkt. ##96-97), and AAPS filed its timely Notice of Appeal on October 21, 2020. (Dkt. #98)

C. Ruling Presented for Review

The district court dismissed under Rule 12(b)(6) both counts in the Amended Complaint of AAPS.

The district court first dismissed the tying portion of Sherman Act Section 1 claim by holding that "[t]he allegations do not plausibly suggest an arrangement to tie MOC

and admitting privileges and / or in-network status between ABMS and a nationwide group of hospitals and / or insurance companies." (A-7)

The district court next dismissed the claim for unlawful agreements to arrange MOC. As a threshold issue, the district court agreed with AAPS that an antitrust violation can exist without one co-conspirator having authority over other co-conspirators. "[T]he fact that ABMS lacks authority or control over its coconspirators does not itself decide whether the alleged coconspirators together restrained trade." (A-12)

But the district court held that such collusion, or conspiracy, was inherently implausible here: "The allegations in the amended complaint do not plausibly allege a nationwide agreement between ABMS and an untold number of hospitals and health insurers." (A-7) The court held that "[t]he sweeping breadth of the alleged market and the sheer number of hospitals and insurance companies that would have to be involved make the alleged agreement implausible." (A-13) The district court concluded that "the amended complaint plausibly alleges neither an unreasonable restraint of trade in a relevant market nor an agreement in the first place." (A-14)

The court held that "to the extent the amended complaint has alleged a restraint on trade, it has not alleged one effected by a conspiracy." (*Id.*) The court recognized that "the AHA (a hospital trade association) 'is an associate member of Defendant ABMS and agrees with it to impose ABMS MOC® on physicians.'" (A-13, quoting Dkt. 49, ¶ 26) But then the court overlooked this affiliation and held that "'an allegation of parallel conduct

and a bare assertion of conspiracy will not suffice.'" (A-13, quoting *Twombly*, 550 U.S. at 556). The court overlooked that ABMS MOC® is being inexplicably imposed despite widespread criticism of it. (Am. Compl., Dkt. #49 ¶¶ 4-5, 60-61)

The district court further held that there were inadequate allegations of a relevant market and market power. (A-9 – A-11) Relying on a decision concerning duplicative relief sought by consumers and also on several decisions from outside of this Seventh Circuit, the district court dismissed at the pleading stage on the grounds that "[t]he market definition in the amended complaint does not plausibly 'correspond to the commercial realities' of the relevant industry." (A-9, quoting *Sharif Pharmacy, Inc. v. Prime Therapeutics, LLC*, 950 F.3d 911, 917 (7th Cir. 2020)). The district court found defective that "[t]he amended complaint does not allege facts that plausibly suggest that consumers distinguish between physicians who are subject to MOC and those who are not."[3] (A-10) The district court also found significant that the pleading did not include Texas and Oklahoma, which prohibit MOC requirements, in the relevant market: "the complaint offers no reason why they would only go to states that allow MOC requirements … [and] provides no reason why these limitations accurately reflect commercial realities." (A-10)

[3] This lack of any consumers distinguishing physicians based on MOC reinforces the validity of the antitrust claim, because it underscores how unjustified MOC is.

As to market power, the lower court recognized that "amended complaint asserts, without elaboration, that health insurers and hospitals themselves have sufficient market power." (*Id.*) But the district court held that "[w]ithout some assertion of the relevant market size and the power wielded by the alleged co-conspirators, there are no facts to support ABMS's alleged market power (with or without the agreements alleged in the complaint)." (A-11, quoting *Sheridan v. Marathon Petroleum Co. LLC*, 530 F.3d 590, 595 (7th Cir. 2008), for the proposition that an allegation of "appreciable economic power" alone is not enough).[4] For all of the foregoing reasons the district court dismissed the Sherman Act claim (Count I).

In addition, the district court dismissed on two bases the state law claim by AAPS under the Illinois Uniform Deceptive Trade Practices Act ("UDTPA"), 815 ILCS 510/2. (A-15)

The lower court first considered the allegation by AAPS that "ABMS calling itself a 'Board' while referring to its arbitrary conditions as 'requirements' is misleading and unfair." (A-15, inner quotations omitted). The district court rejected the allegation by AAPS that the use by ABMS of the term "Board" "misleadingly implies that ABMS 'has some authority akin to an official state medical board, when in fact Defendant and its co-conspirators lack any official legitimacy.'" (A-15, quoting Dkt. #49, at 20 ¶ 110). The lower court found that "[t]he amended complaint does not plausibly allege how an ordinary

[4] The Court did not reach the issue of antitrust injury. (A-14)

person would infer 'official state authority' upon hearing 'board.'" (A-15) The court concluded that "Boards come in a variety of forms and are not always official state government entities." (*Id.*) The court held that "[t]he amended complaint does not plausibly allege that 'requirements' implies such oversight, particularly when many 'requirements' without a formal legal, governmental, or academic mandate exist." (*Id.*)

The district court further rejected the allegation by AAPS that the alleged communications by ABMS were "about an identifiable good or service." (*Id.*) Relying on a decision that dismissed a trade disparagement claim for lack of a nexus with Illinois, the court held that "under the UDTPA a plaintiff must allege that defendant published untrue or misleading statements that disparaged the plaintiff's goods or services." (*Id.*, quoting *Maui Jim, Inc. v. SmartBuy Guru Enters.*, 386 F. Supp. 3d 926, 939 (N.D. Ill. 2019), inner citation omitted). AAPS sued on behalf of its physician member's medical services, but the district court did not address that as it dismissed this state law claim (Count II).

SUMMARY OF ARGUMENT

In a complaint against restraint of trade by a non-governmental entity (ABMS) arranging for imposition of its unwanted, burdensome certification, the district court over-relied on its own views about plausibility in order to reject allegations of collusion. In so holding, the district court misapplied the standards of *Twombly* and *Iqbal* in order to resort heavily to presumptions of fact found nowhere in the record. This was an error of law: the only plausible way that an unwanted certification burden is imposed on a

free market is if there is collusion to impose it. The possibility of independent entities imposing an unwanted certification burden as purely parallel conduct is far less plausible. But there is no need to speculate about plausibility when discovery could have, and should have, been allowed concerning how ABMS's proprietary, widely criticized certification is being broadly imposed.

Non-governmental, widely criticized certifications are typically not imposed by others without inducement. Where, as here, a trade association of hospitals is a member of the defendant (ABMS) as it sells its proprietary certification, inducements through the trade association to impose the certification are highly likely. Water does not spontaneously boil, avalanches do not slide uphill, and there are no perpetual free lunches. Whether the arrangements by ABMS to induce others to impose its proprietary certification constitute an unlawful restraint of trade is not to be resolved at the pleading stage based on assumptions, but after development of a factual record.

The district court further erred in dismissing, again without allowing factual development, the claim against ABMS for deceptive trade practices in promoting the sale of its product by misleadingly disparaging those who choose not to buy it. It was an error of law for the district court to make findings of fact based only on the pleading as to whether the disparaging use by ABMS of the terms "requirements" (which strongly connotes some kind of regulatory requirement) and "Board" (which commonly connotes a regulatory entity, such as a state medical board) constitute an unfair business practice.

When courts use the term "requirement" it usually connotes some kind of legal obligation, particularly when used in conjunction with the term "Board", as in "Board requirement," yet the district court made a premature factual determination otherwise at the pleading stage.

In sum, and as explained further below, it was a reversible error for the lower court to dismiss at the pleading stage these claims of an antitrust violation and deceptive trade practices.

ARGUMENT

I. Standard of Review.

The review by this Court is *de novo* here. "We review a 12(b)(6) dismissal *de novo* and construe all allegations and any reasonable inferences in the light most favorable to the plaintiff." *League of Women Voters v. City of Chi.*, 757 F.3d 722, 724 (7th Cir. 2014) (citing *Killingsworth v. HSBC Bank Nevada, N.A.*, 507 F.3d 614, 618 (7th Cir. 2007)).

II. The District Court Impermissibly Made Factual Assumptions Contrary to the Complaint in Order to Dismiss it for a Perceived Lack of Plausibility.

The purpose of the Sherman Act is to protect consumers from injury that results from diminished competition. *Banks v. NCAA*, 977 F.2d 1081, 1087 (7th Cir. 1992). There is such injury when patients are unable to access the physician of their choice, at a hospital or in a health insurance network, due to an unjustified barrier created by a proprietary

certification scheme. Defendant ABMS increases its revenues by obtaining imposition of its proprietary certification, which results in the denial of access by patients to physicians who do not purchase and comply with ABMS's product. This denial of access is plainly within the purpose of the Sherman Act to prevent; a cause of action exists to challenge the restraint of trade in this form of an unjustified imposition of proprietary certification as a condition of providing medical care to patients.

There is nothing implausible about a private, revenue-maximizing entity, such as ABMS, arranging with other entities to require its proprietary certification product. In the absence of enforcement of antitrust law, a revenue-maximizing certifying company would increase its income by offering inducements to other entities for requiring its certification. Dismissal of allegations of such anti-competitive conduct at the pleading stage is tantamount to creating an exemption from the Sherman Act for Defendant ABMS, which of course Congress never intended or authorized.

A. AAPS Adequately Alleged a Restraint of Trade Based on Collusion by ABMS to Impose Its Proprietary Certification Product.

The district court erred in relying too heavily on its own view of plausibility: "The question is whether the complaint has plausibly alleged an unreasonable restraint of trade under the *per se* rule or the rule of reason." (A-7) This expansive variation of the legal standard invites a court to speculate, without the benefit of factual development, about plausibility in thwarting any factual development. Essentially, this test would have a court weigh the facts based not on admissible evidence, but on preconceived,

possibly uninformed perceptions by a court about a case. This variation on the test is not the correct standard under *Twombly*, or any other applicable precedent.

AAPS alleged, with as much specificity as could reasonably be expected, how ABMS obtains the imposition of its board certification by hospitals through the American Hospital Association (AHA), which is a member of ABMS. "The American Hospital Association ('AHA'), a trade association representing nearly all hospitals in the United States, is an associate member of Defendant ABMS and agrees with it to impose ABMS MOC® on physicians." (Am. Compl., Dkt. #49, ¶ 26) ABMS has a Portfolio Program™ by which it requires of hospitals that they agree and represent that they have "'a willingness to commit necessary resources and consider MOC a requirement for medical staff privileges for eligible physicians.'" (*Id.* ¶ 28, quoting a public statement by ABMS). Reasonable inferences are that arrangements by ABMS to impose its certification exist. Discovery has not yet been allowed in this case, so of course agreements themselves have not yet been uncovered. It constituted an error of law for the district court to dismiss the Amended Complaint without even allowing review of the details behind the publicly announced arrangement between ABMS and hospitals concerning imposition by hospitals of ABMS certification.

The district court acknowledged that "ABMS has referenced its 'campaign to induce hospitals to impose the ABMS MOC® product as a condition of holding medical staff privileges.'" (A-13, quoting Dkt. 49, ¶ 27) Yet without discovery, AAPS has no way

to uncover what that "campaign to induce" specifically entails. There is nothing implausible about the inclusion of compensation or mutually beneficial commitments as inducements for this restraint of trade. At the pleading stage, the court should draw such reasonable inferences in favor of the plaintiff, which the district court below failed to do.

As to insurance companies, the district acknowledged the allegations by Plaintiff AAPS that:

> ABMS allegedly "publicly admits that it encouraged and obtained a commitment by the Blue Cross and Blue Shield Association ('BCBSA') to require physicians to purchase and participate in ABMS MOC® as a condition of physicians being in-network with health insurance plans," causing "Blue Cross and Blue Shield-affiliated health plans in multiple states," such as Blue Cross and Blue Shield of Massachusetts and Independence Blue Cross of Pennsylvania, to impose such a requirement.

(A-13) "Obtaining a commitment" is tantamount to an agreement. Determining whether that agreement was a violation of the Sherman Act requires reviewing the commitment, rather than dismissing allegations of a violation without discovery of the facts. There is nothing implausible about the allegation that insurance companies entered into some kind of agreement or understanding to require the proprietary certification by ABMS, which has the effect of limiting patient access to physicians of their choice.

Despite the above allegations and reasonable inferences that must be drawn from them at this preliminary stage, the district court held that "even if these allegations plausibly suggested an agreement with Blue Cross and Blue Shield-affiliated health plans in particular (which they do not), they still would not plausibly suggest a nationwide

agreement between insurers, hospitals, and ABMS." (A-14) The district court added that "[t]he complaint also offers no explanation for why hospitals and insurers would enter into an agreement that allegedly reduces the output and increases the cost of physician care just to benefit ABMS." (*Id.*)

In fact, improper arrangements are common in the vast health care sector of the economy, and there is nothing implausible about their existence. Kickbacks and other forms of improper arrangements in the health care industry are so pervasive that laws have been enacted to specifically prohibit them, such as the Anti-Kickback Statute to ban kickbacks in connection with the Medicare program. 42 U.S.C. § 1320a-7(b). Moreover, unlawful tying is hardly implausible in connection with board certification. *See Talone v. Am. Osteopathic Ass'n*, No. 1:16-cv-04644-NLH-JS, 2017 U.S. Dist. LEXIS 89395, at *10-16 (D.N.J. June 12, 2017) (denying a motion to dismiss a tying claim concerning board certification). There is nothing implausible about a certifying organization colluding and agreeing with other entities to compel purchase of its proprietary certification. Straightforward, focused discovery would readily determine whether such arrangements exist, and whether they are improper.

Actions in antitrust (and any other field of law) are not to be dismissed based on factual assumptions concerning plausibility by a district court. The Supreme Court reiterated in *Twombly* itself that "Rule 12(b)(6) does not countenance ... dismissals based on a judge's disbelief of a complaint's factual allegations." *Twombly*, 550 U.S. at 556

(quoting *Neitzke* v. *Williams*, 490 U.S. 319, 327 (1989)). *Twombly* also explained that "a well-pleaded complaint may proceed even if it appears 'that a recovery is very remote and unlikely.'" *Twombly*, 550 U.S. at 556 (quoting *Scheuer* v. *Rhodes*, 416 U.S. 232, 236 (1974)). *See also Schuchardt v. President of the United States*, 839 F.3d 336, 348 (3d Cir. 2016) ("'It is the conclusory nature of respondent's allegations, rather than their extravagantly fanciful nature, that disentitles them to the presumption of truth.'") (quoting *Iqbal*, 556 U.S. at 681).

As Judge Easterbrook has explained:

> The district court thought that count 3 does not narrate a "plausible" claim, as the Supreme Court used that word in *Ashcroft v. Iqbal*, 556 U.S. 662, 129 S. Ct. 1937, 173 L. Ed. 2d 868 (2009), and *Bell Atlantic Corp. v. Twombly*, 550 U.S. 544, 127 S. Ct. 1955, 167 L. Ed. 2d 929 (2007). ***Yet those decisions concern the adequacy of the notice given by the pleading, not the claim's legal substance***. The Court held that Fed. R. Civ. P. 8 is not satisfied by a skeletal complaint that contains conclusion or surmise and requires a court to decide whether events not pleaded could be imagined in a plaintiff's favor. The Court wrote that judges may bypass implausible allegations and insist that complaints contain enough detail to allow courts to separate fantasy from claims worth litigating. *Iqbal* and *Twombly* do not change the standards for judgment on the pleadings (Rule 12(c)) or summary judgment (Rule 56), nor do they require complaints to address potential defenses such as the Business Judgment Rule. The Court held in *Gomez v. Toledo*, 446 U.S. 635, 100 S. Ct. 1920, 64 L. Ed. 2d 572 (1980), that complaints need not anticipate affirmative defenses; neither *Iqbal* nor *Twombly* suggests otherwise. See *Richards v. Mitcheff*, 696 F.3d 635 (7th Cir. 2012). ***So although count 3 may not have much prospect, it could not be dismissed at the suit's outset***.

Levin v. Miller, 763 F.3d 667, 671 (7th Cir. 2014) (emphasis added). *Cf. Stuart v. Local 727, Int'l Bhd. of Teamsters*, 771 F.3d 1014, 1018 (7th Cir. 2014) (Posner, J.) ("A plaintiff is not

required to negate an affirmative defense in his or her complaint ….") (relying on *Levin* and *Gomez v. Toledo*, 446 U.S. 635, 640 (1980)).

This standard does not invite or permit a court, in reviewing a motion to dismiss, to make its own factual assumptions contrary to the allegations in the pleading, and then dismiss it based on those factual assumptions, as the court below did below. When "the district court assumed away a key, apparently disputed, issue of fact," then that is "incorrect on a motion to dismiss" and the decision must be reversed. *Rankow v. First Chi. Corp.*, 870 F.2d 356, 367 (7th Cir. 1989), *abrogated on other gnds*, *Fireman's Fund Ins. Co. v. SEC Donohue, Inc.*, 176 Ill. 2d 160, 679 N.E.2d 1197, 1201, 223 Ill. Dec. 424 (Ill. 1997). As the *Rankow* court explained:

> This is perhaps an apt case in which to recall the lesson of *Conley v. Gibson*: "The Federal Rules of Procedure do not require a claimant to set out in detail the facts on which he bases his claim." 355 U.S. 41, 47, 78 S. Ct. 99, 2 L. Ed. 2d 80 (1957). Nor do they require a claimant to demonstrate that proof based on the pleadings will prevail.

Rankow v. First Chi. Corp., 870 F.2d at 367-68.

B. AAPS Alleged a Sufficient Relevant Market and Market Power.

AAPS expressly alleged that:

> Approximately 80% of hospitals now require certification by ABMS as a condition for physicians to be on the medical staff, and outside of Texas and Oklahoma nearly all of those hospitals now require that physicians purchase and spend enormous time on the proprietary product of ABMS MOC® in order to have medical staff privileges.

(Am. Compl., Dkt. #49, ¶ 31) In addition to the hospitals' requiring this certification, most health insurers require it also, as expressly alleged by AAPS:

> Most health insurers, particularly in metropolitan areas, require that physicians purchase and comply with Defendant's ABMS MOC® product as a condition of being in-network with the insurer.

(*Id.* ¶ 24)

AAPS alleged that the relevant market is as follows:

> 67. The relevant service market consists of medical care provided by physicians who are subject to MOC, and who are either in-network, or seek to be in-network, with health insurers, or treat or seek to treat hospitalized patients.
>
> 68. The relevant geographic market is nationwide except for States that have generally prohibited MOC requirements, as Texas has.

(Id. ¶¶ 67-68)

Despite these allegations, the district court wrote at length that AAPS failed to allege an adequate relevant market and market power within that market. (A-9 - A-11) The court relied on a definition of market power as where entities are "able to raise the prices of physician care—effectively in a nationwide market—without going out of business." (A-10) But health care is highly regulated and substantially taxpayer funded; this case is not based on pricing which is largely dictated by government reimbursement programs such as Medicare. This case is about limiting output, by excluding physicians from the relevant market through the restraint of trade of requiring purchase of the ABMS MOC® product, and thereby denying access by patients to the physicians of their choice.

Where, as here, a restraint of trade on output is alleged, it is akin to a naked restraint such that it is not necessary to plead market power with great detail:

> As a matter of law, the absence of proof of market power does not justify a naked restriction on price or output. To the contrary, when there is an agreement not to compete in terms of price or output, "no elaborate industry analysis is required to demonstrate the anticompetitive character of such an agreement."

Nat'l Collegiate Athletic Ass'n v. Bd. of Regents, 468 U.S. 85, 109 (1984) (quoting *Nat'l Soc'y of Prof'l Eng'rs v. United States*, 435 U.S. 679, 692 (1978)). Moreover, market power exists for the proprietary ABMS MOC® product, on which ABMS holds a monopoly and 80% of hospitals require it. (Am. Compl., Dkt. 49, ¶¶ 13-15, 31) The very fact that "multiple state legislatures have taken the extraordinary step of prohibiting the imposition of requirements based on" ABMS MOC® confirms the immense market power held by ABMS and its co-conspirators. (*Id.* ¶ 4)

In addition, AAPS expressly alleged market power as follows:

> 18. Defendant ABMS has conspired with health insurers having market power, in order to compel physicians to purchase the ABMS MOC® product. …
>
> 25. Defendant ABMS has sought and obtained agreement by hospitals having market power, in order to enforce Defendant's ABMS MOC® product as a condition of holding medical staff privileges. …
>
> 86. Defendant's foregoing conduct constitutes an unlawful tying agreement under Section 1 of the Sherman Act, where health insurers and hospitals having sufficient market power are induced by Defendant to require purchase of its product by physicians.

(*Id.* ¶¶ 18, 25, 86) This is adequate, particularly for a direct restraint on output through imposition of an unjustified proprietary maintenance of certification product.

Despite this, the district court held that AAPS failed to provide "any facts substantiating the alleged market share belonging to the American Hospital Association, the Blue Cross and Blue Shield Association, or any other participant in the alleged market." (A-11) But, in fact, AAPS expressly alleged that the "American Hospital Association ('AHA') [is] a trade association representing nearly all hospitals in the United States [and] is an associate member of Defendant ABMS and agrees with it to impose ABMS MOC® on physicians." (Am. Compl., Dkt. #49, ¶ 11) As to the market power of Blue Cross and Blue Shield insurers, it can hardly be doubted.

The district court went in an incorrect direction when it found that "[t]he amended complaint does not allege facts that plausibly suggest that consumers distinguish between physicians who are subject to MOC and those who are not." (A-10) Indeed, AAPS rejects the notion that MOC has any value, or that consumers distinguish physicians based on it. The lack of any MOC benefit ***reinforces*** the lack of any justification for excluding physicians based on it. The absence of perception by consumers of any value to MOC ***underscores*** how restraining trade based on it is a Sherman Act violation.

It is this very lack of value to ABMS's certification product which supports the plausibility of the alleged antitrust violation, under the test restated by the district court: "All of these methods of [antitrust] analysis are meant to answer the same question: whether or not the challenged restraint enhances competition." (A-6, quoting *Agnew v. NCAA*, 683 F.3d 328, 335 (7th Cir. 2012)). The challenged restraint – imposition of an

unjustified, widely criticized form of certification – plainly impedes competition rather than enhance it, and thus constitutes a Sherman Act violation.

The district court misplaced reliance on a decision which rejected the notion that a particular brand of gasoline – Marathon – was its own separate product market. "'Not even the most zealous antitrust hawk has ever argued that Amoco gasoline, Mobil gasoline, and Shell gasoline' – or, we interject, Marathon gasoline – 'are three [with Marathon, four] separate product markets.'" *Sheridan v. Marathon Petroleum Co., LLC*, 530 F.3d 590, 595 (7th Cir. 2008) (quoting *Generac Corp. v. Caterpillar, Inc.*, 172 F.3d 971, 977 (7th Cir. 1999) while adding the brackets). The facts in *Sheridan* entailed a tying requirement of franchisees of Marathon gasoline stations to use Marathon credit card processing services when buyers presented a Marathon credit card, which the franchisee had to accept. The district court quoted *Sheridan* for the proposition that "under the pleading regime created by [*Twombly*], the plaintiffs' naked assertion of Marathon's 'appreciable economic power' – an empty phrase – cannot save the complaint." *Sheridan*, 530 F.3d at 595. But Marathon's total gasoline sales amounted to only 4.3 percent of all U.S. gasoline sales per year, and "[t]hat is no one's idea of market power." *Id.* In stark contrast, ABMS has colluded to control the granting of medical staff privileges at nearly 80% of hospitals, with ABMS's proprietary MOC product. (Am. Compl., Dkt. #49, ¶ 31)

Judge Posner explained in the *Sheridan* decision that "[t]he word 'monopoly' in the expression 'monopoly power' was never understood literally, to mean a market with only one seller." *Sheridan*, 530 F.3d at 594. ABMS controls MOC, and hospitals require it.

C. The Tying Aspect of AAPS's Claim Should Not Have Been Dismissed.

As correctly restated below, there is a three-pronged test for an illegal tying:

(1) the tying arrangement is between two distinct products or services,

(2) the defendant has sufficient economic power in the tying market to appreciably restrain free competition in the market for the tied product, and

(3) a not insubstantial amount of interstate commerce is affected.

(A-6, quoting *Reifert v. S. Cent. Wisconsin MLS Corp.*, 450 F.3d 312, 316 (7th Cir. 2006) (citations omitted)). The district court characterized the allegations as being that "ABMS, insurers, and hospitals are colluding to tie a product unwanted by physicians (MOC) to the provision of 'services' wanted by physicians (in-network status and / or hospital privileges, if these can even be considered 'services')." (A-7) The court dismissed this claim, however, by finding that the allegations were insufficient concerning "two products or services." (*Id.*)

But it is collusion by ABMS with hospitals and insurers which ties the ABMS product to hospital privileges and insurance networks, and thereby compels physicians to purchase the ABMS MOC product. Admittedly, this is not as simple a tying arrangement as common textbook examples, but this is plainly anti-competitive and it does satisfy all three of the foregoing elements of an antitrust tying violation.

First, there are two distinct products or services here: (1) MOC and (2) medical staff privileges and/or insurance network coverage. Physicians needing medical staff privileges (and in-network status in insurance networks) cannot obtain that without also obtaining MOC, a product that they do not independently want. ABMS is the wrongdoer here; its collusion to attach MOC to medical staff privileges and in-network insurance status subjects ABMS to a valid antitrust claim for tying. Ruling otherwise would constitute a judicially created loophole for anti-competitive tying.

It was an error of law for the district court to implicitly narrow tying doctrine by requiring a textbook-style tying arrangement, whereby one and only one company forces consumers to buy from it a product that consumers do not want, in order to buy from the very same company a product the consumers need. Multiple entities acting in concert should not be allowed to impede competition in the same way that only one firm is admittedly prohibited from doing. Colluding to engage in tying is actionable as unlawful tying as much as tying by only one entity is. The district court erred as a matter of law in dismissing this claim.

III. The District Court Prematurely Dismissed the Claim for Deceptive Trade Practices.

Deceptive trade practices are prohibited by Illinois law, yet ABMS persists in making misleading statements about participation in its MOC program. Count II of the Amended Complaint asserted a claim under the Illinois Uniform Deceptive Trade Practices Act, 815 ILCS 510/2.

ABMS posted a statement that physicians who merely decline to purchase its requirement are "Not Meeting MOC Requirements," as alleged in the Amended Complaint. (Am. Compl., Dkt. #49, ¶ 100)

Despite this and other misleading statements by ABMS about individual physicians, to the detriment of their reputations in a profession where reputation counts for everything, the district court dismissed this claim. The applicable statute under the UDTPA is as follows, as restated by the lower court:

> The Act provides as relevant:
>
> (a) A person engages in a deceptive trade practice when, in the course of his or her business, vocation, or occupation, the person: ...
> (8) disparages the goods, services, or business of another by false or misleading representation of fact ....

815 ILCS 510/2(a)(8) (additional citations omitted).

By incorrectly characterizing its MOC program as "requirements", ABMS creates a false impression that there is some kind of governmental mandate behind its product, when there is not. This connotation is particularly strong in the highly regulated field of medicine, where a "requirement", particularly one by a "Board", is generally understood to mean some kind of binding regulation. The following passage in a Supreme Court decision illustrates the common usage of the term "requirement" in health care:

> And several of Congress' legislative "findings" with regard to §5000A confirm that it sets forth a legal requirement and constitutes the assertion of regulatory power, not mere taxing power. See 42 U.S.C. §18091(2)(A) ("The ***requirement regulates*** activity ..."); §18091(2)(C) ("The ***requirement*** ... will add millions of new consumers to the health insurance market ..."); §18091(2)(D) ("The requirement

> achieves near-universal coverage"); §18091(2)(H) ("The ***requirement*** is an essential part of this larger ***regulation*** of economic activity, and the absence of the ***requirement*** would undercut Federal ***regulation*** of the health insurance market");

Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 663 (2012) (emphasis added).

Amid an official connotation of the term "requirements" as used with the term "Board", the district court nevertheless held that "Boards come in a variety of forms and are not always official state government entities." (A-15) "[N]ot always," indeed, but in the vast majority of the usage of the term "board" in connection with "requirements" the term "board" refers to some kind of governmental agency: a state medical board, the National Labor Relations Board, state lottery boards, and many additional governmental regulatory boards. There are also private boards, of course, but they can impose "requirements" only when there is a contractual obligation entered into with the board, such as a condominium board, of which there is none relevant to this case. When "requirements" are combined with the term "Board" a clear connotation of governmental authority exists. The Ninth Circuit once held that the phrase "board certified" had a particular meaning in the medical context, but that factual finding was made on summary judgment rather than a motion to dismiss, and "board certified" has a different meaning from "board requirements." *Am. Acad. of Pain Mgmt. v. Joseph*, 353 F.3d 1099, 1101 (9th Cir. 2004).

When the term "board requirements" is used by courts, it refers to a statutory requirement of certification by a specialty board in connection with testifying as an expert

in a case. *See Gbur v. Golio*, 600 Pa. 57, 89, 963 A.2d 443, 463 (2009) (considering the argument that "board requirements of the MCARE Act precluded Dr. Sanford, a radiation oncologist, from testifying to the standard of care applicable to Appellant, a urologist"). Speaking in terms of "board requirements" for a board which has no authority to impose any requirements, as ABMS does, is inherently misleading. "Board requirements" implies an authority to impose requirements, and where no such authority exists, as with ABMS, it is a deceptive phrase that misleads.

Yet without the benefit of factual development below, the district court held that:

> The amended complaint does not plausibly allege that "requirements" implies such oversight, particularly when many "requirements" without a formal legal, governmental, or academic mandate exist.

(A-15) The district court did not provide any examples of those "many" requirements imposed by purely private entities, and it is difficult to think of any. In our free society, a private entity cannot require, without legal authority, anyone to do anything to which he has not consented. Even contractual obligations are merely promises to perform, or decline to perform and instead pay damages. ABMS does not base its use of the term "requirements" on any contractual obligations.

Stating publicly that a physician is not meeting a Board's "requirements" is detrimental to that physician, and ABMS thereby increases the pressure to buy its proprietary product. If any private company could shame or embarrass buyers who decide not to purchase its product, then many private companies might try to increase

their product sales that way. Physicians rely heavily on a good professional reputation in order to practice medicine, and harming that reputation to induce purchase of MOC is an unfair, deceptive way for ABMS to increase the sales of its product. This conduct by ABMS is what the UDTPA prohibits, and it was legal error for the court below to dismiss AAPS's claim on this.

The additional basis cited by district court for dismissing the state law claim was likewise defective:

> Finally, AAPS's general allegations about ABMS, *e.g.*, [49] at 19 ¶¶ 105, 107, do not plausibly allege communications about an identifiable good or service. *See Associated Underwriters*, 826 N.E.2d at 1169; *Maui Jim, Inc. v. SmartBuy Guru Enterprises*, 386 F. Supp. 3d 926, 939 (N.D. Ill. 2019) ("under the UDTPA a plaintiff must allege that defendant published untrue or misleading statements that disparaged the plaintiff's goods or services") (citation omitted).

(A-15)

Contrary to the ruling below, the identifiable good or service is clear here: the practice of medicine by AAPS members, which ABMS disparages by saying they do not meet MOC requirements. AAPS members are thereby injured by this disparagement by ABMS. (Dkt. #49, ¶ 117) ABMS does this to increase purchases of its MOC product by physicians, lest they suffer the disparagement, and such conduct by ABMS goes to the heart of what the UDTPA stands against.

AAPS also alleged the following additional facts indicating a violation of the UDTPA by ABMS:

> 107. … Defendant withholds from the public that it arbitrarily

> exempts many thousands of physicians from its "MOC Requirements," and yet deceptively conceals how arbitrary its exemptions are, while disparaging physicians who are not considered by Defendant to be exempt.
>
> 108. Defendant's ABMS MOC® program is designed primarily to increase the revenue to ABMS and its Specialty Boards, and increase the compensation to their executives, rather than engage in any genuine attempt to improve quality of care for patients.
>
> 109. Many of the questions asked of physicians as part of Defendant's ABMS MOC®, for which physicians must provide Defendant's preferred answer choices in order to be recertified, have no relevance to the quality of care that the physician provides, and there is no meaningful academic or governmental oversight, public accountability or transparency as to whether the answer choices considered "correct" by Defendant are actually the best answers.

(Am. Compl., Dkt. #49, ¶ 107-09)

At a minimum, discovery should have proceeded on this issue in order to allow resolution at summary judgment or trial, not on a motion to dismiss.

IV. It Was an Error to Dismiss "With Prejudice."

The dismissal below should not have been "with prejudice." When agreements and arrangements are not publicly disclosed, a plaintiff at the outset of a case is unable to plead with particularity what those details are. *See Humana Inc. v. Forsyth*, 525 U.S. 299, 303 (1999) (allowing allegations about a concealed agreement to proceed to trial). At most, the district court should have held that the dismissal of the complaint would be without prejudice. Additional facts may later come to light which could bolster future claims against ABMS for restraining trade for its own pecuniary advantage. Dismissal of this action "with prejudice" emboldens revenue-maximizing entities to restrain trade

with impunity, as long as arrangements are concealed. Such premature dismissals encourage companies with market power to risk never being caught in arrangements that maximize their revenues by restraining trade. If discovery is never allowed, then the likelihood of accountability is minimal.

Examples where this court has upheld a dismissal with prejudice illustrate that it should be limited to where "a court's order … highlighted the specific problem in [a] claim … [and] the plaintiff has repeatedly failed to remedy the same deficiency." *GE Capital Corp. v. Lease Resolution Corp.*, 128 F.3d 1074, 1085 (7th Cir. 1997). If new evidence surfaced tomorrow that supports AAPS's claims, it would be unfairly precluded by the "with prejudice" ruling by the decision below as based on unsupported perceptions about plausibility. The dismissal should have at most been "without prejudice."

CONCLUSION

For the foregoing reasons, the decision below should be entirely reversed.

Dated: March 8, 2021

Respectfully submitted,

s/ Andrew L. Schlafly

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CERTIFICATE OF COMPLIANCE

This document complies with the type-volume limitations of Fed. R. App. P. 32(a)(7)(B) and Circuit Rule 32, because this document contains 10,109 words, excluding the parts of the document exempted by Fed. R. App. P. 32(f).

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Dated: March 8, 2021

s/ Andrew L. Schlafly
Andrew L. Schlafly
Attorney for the Plaintiff-Appellant
Association of American Physicians & Surgeons, Incorporated

CIRCUIT RULE 30(d) STATEMENT

Pursuant to Circuit Rule 30(d), counsel certifies that all material required by Circuit Rule 30(a) and (b) are included in the Appendix.

s/ Andrew L. Schlafly
Andrew L. Schlafly

CERTIFICATE OF SERVICE

I hereby certify that on March 8, 2021, the Brief of Appellant was filed with the Clerk of the Court for the United States Court of Appeals for the Seventh Circuit by using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

s/ Andrew L. Schlafly
Andrew L. Schlafly

APPENDIX

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UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF ILLINOIS
EASTERN DIVISION

ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC.,

Plaintiff,

v.

AMERICAN BOARD OF MEDICAL SPECIALTIES,

Defendant.

Case No. 14-cv-02705

Judge Martha M. Pacold

MEMORANDUM OPINION AND ORDER

Plaintiff Association of American Physicians & Surgeons, Inc. ("AAPS") sued Defendant American Board of Medical Specialties ("ABMS") regarding ABMS's Maintenance of Certification ("MOC") program for physicians. Originally, AAPS brought a claim for restraint of trade under Section 1 of the Sherman Act and a negligent misrepresentation claim. ABMS moved to dismiss AAPS's complaint. The court granted the motion with leave to amend. [48]. AAPS filed an amended complaint reasserting the restraint of trade claim under the Sherman Act and asserting, instead of negligent misrepresentation, a claim under the Illinois Uniform Deceptive Trade Practices Act, 815 ILCS 510/2. [49]. ABMS moved to dismiss the amended complaint under Rule 12(b)(6). [51]. The motion is granted.

BACKGROUND

The court assumes familiarity with Judge Wood's opinion dismissing the original complaint, *Ass'n of Am. Physicians & Surgeons, Inc. v. Am. Bd. of Med. Specialties*, No. 14-cv-02705, 2017 WL 6821094 (N.D. Ill. Dec. 13, 2017), and the decision of the U.S. District Court for the District of New Jersey transferring this action to this district pursuant to 28 U.S.C. § 1406(a), *Ass'n of Am. Physicians & Surgeons, Inc. v. Am. Bd. of Med. Specialties*, No. Civ. A. 13-2609 PGS, 2014 WL 1334260 (D.N.J. Apr. 2, 2014).

In considering a Rule 12(b)(6) motion, "[t]he complaint's well-pleaded factual allegations, though not its legal conclusions, are assumed to be true." *Phillips v. Prudential Ins. Co. of Am.*, 714 F.3d 1017, 1019 (7th Cir. 2013). "The facts are set forth as favorably to [the plaintiff] as those materials allow. . . . In setting forth those facts at the pleading stage, the court does not vouch for their accuracy."

McWilliams v. Cook Cty., No. 15-cv-00053, 2018 WL 3970145, at *1 (N.D. Ill. Aug. 20, 2018) (citations omitted).

The amended complaint alleges as follows. Plaintiff, AAPS (again, the Association of American Physicians & Surgeons, Inc.), is a nonprofit membership organization of physicians in virtually all specialties. Am. Compl., [49] at 3 ¶ 7.[1] Defendant, ABMS (again, the American Board of Medical Specialties), is a nonprofit entity headquartered in Chicago, Illinois. [49] at 3 ¶ 8.

ABMS offers a voluntary certification program for physicians that is "not required to be licensed to practice medicine." [48] at 2. Certification does not last for life; to remain certified, physicians must participate in a "recertification" program known as "ABMS Maintenance of Certification®" ("MOC"). [48] at 2; [49] at 5 ¶ 13.

According to the complaint, ABMS has conspired with three types of entities to impose ABMS's MOC program on physicians: (1) 24 separate corporations known as "specialty boards," (2) health insurers, and (3) hospitals. [49] at 5–8 ¶¶ 13–31.

The 24 specialty boards (which are not defendants) are member medical boards of ABMS that relate to particular medical specialties. *Ass'n of Am. Physicians & Surgeons*, 2014 WL 1334260, at *1. Examples include the American Board of Allergy and Immunology, the American Board of Anesthesiology, the American Board of Colon and Rectal Surgery, the American Board of Dermatology, and the American Board of Emergency Medicine. [49] at 5 ¶ 14. The complaint alleges that ABMS and its member medical specialty boards "have conspired to impose" the MOC program on all physicians who hold an M.D. degree, "with arbitrary exemptions for older physicians." [49] at 5 ¶ 15.

As to health insurers and hospitals (which also are not defendants), the complaint alleges that ABMS "has conspired with health insurers and hospitals to require physicians to purchase the ABMS MOC® product as a condition of being in health plan networks or having medical staff privileges, respectively." [49] at 5–6 ¶ 16.

With respect to health insurers specifically, the complaint alleges that "ABMS has conspired with health insurers having market power, in order to compel physicians to purchase the ABMS MOC® product." [49] at 6 ¶ 18. The complaint alleges that "[f]or example, Defendant ABMS publicly admits that it encouraged and obtained a commitment by the Blue Cross and Blue Shield Association ('BCBSA') to require physicians to purchase and participate in ABMS MOC® as a condition of physicians being in-network with health insurance plans, causing "Blue

[1] Bracketed numbers refer to entries on the district court docket and are followed by the page and / or paragraph number. Page number citations refer to the ECF page number.

Cross and Blue Shield-affiliated health plans in multiple states," such as Blue Cross and Blue Shield of Massachusetts and Independence Blue Cross of Pennsylvania, to impose such a requirement. [49] at 6 ¶¶ 19–22. The complaint alleges that "[i]n addition, Defendant ABMS has colluded with other groups to induce health insurers to 'use Board Certification by an ABMS Member Board as an essential tool to assess physician credentials within a given medical specialty.'" [49] at 6 ¶ 23 (footnote omitted). Ultimately, "[m]ost health insurers, particularly in metropolitan areas, require that physicians purchase and comply with Defendant's ABMS MOC® product as a condition of being in-network with the insurer." [49] at 7 ¶ 24.

As for hospitals, the complaint alleges that "Defendant ABMS has sought and obtained agreement by hospitals having market power, in order to enforce Defendant's ABMS MOC® product as a condition of holding medical staff privileges." [49] at 7 ¶ 25. According to the complaint, the American Hospital Association ("AHA"), a trade association representing nearly all hospitals in the United States, is an associate member of ABMS and has agreed with ABMS to impose the MOC program on physicians. [49] at 7 ¶ 26. Further, the complaint alleges, "In Defendant ABMS's 'Portfolio Program™,' ABMS explains its campaign to induce hospitals to impose the ABMS MOC® product as a condition of holding medical staff privileges," and "ABMS requires of hospitals as a condition of joining its Portfolio Program™ that the hospital agree and represent that it has 'a willingness to commit necessary resources and consider MOC a requirement for medical staff privileges for eligible physicians.'" [49] at 7–8 ¶¶ 27–28 & n.6.[2] Approximately 80% of hospitals nationwide now require physicians to have ABMS certification to be on the medical staff. [49] at 8 ¶ 31. Within that group of hospitals, outside of Texas and Oklahoma (which as discussed below have enacted laws regarding MOC), nearly all now require that physicians purchase the MOC program to have medical staff privileges. [49] at 8 ¶ 31.

ABMS's MOC program has affected the practice of individual doctors. An AAPS physician member identified as "J.E.," who had been on the staff of the Somerset Medical Center in Somerville, New Jersey for twenty-nine years, chose not to participate in the MOC program. [49] at 9 ¶¶ 34–36. In 2011, the Somerset Medical Center refused to allow J.E. to continue to remain on its medical staff unless he purchased and complied with MOC. [49] at 9 ¶ 35. J.E. had been fully certified in good standing with a predecessor to one of the specialty boards. [49] at 9 ¶ 37. Effective June 24, 2011, the Somerset Medical Center excluded J.E. from its medical staff due to ABMS's activities and agreements to impose the MOC program. [49] at 9 ¶ 39. J.E., like many other AAPS physicians, spends a substantial percentage of his time providing charity care to patients who would not otherwise have access to medical care. [49] at 9 ¶ 40. The complaint explains that "J.E.

[2] The complaint cites the December 2016 Standards and Guidelines for Program Sponsorship for ABMS's Portfolio Program, [49] at 8 n.6, but does not describe the features or function of the program.

manages and works in a standalone medical charity clinic for a substantial part of each week." [49] at 10 ¶ 49. "J.E. continued to serve his non-hospitalized charity patients rather than comply with the immense burdens of recertification demanded by Defendant's agreements to implement ABMS MOC®." [49] at 10–11 ¶ 52. Such patients are "denied the benefit of being evaluated and treated by J.E. when taken by emergency to [Somerset Medical Center]." [49] at 9 ¶ 41.

Physicians spend more time in training than most other professionals. [49] at 10 ¶ 45. The "additional burdens on physicians' time imposed by the [MOC] product is substantial, often exceeding 100 hours per year." [49] at 10 ¶ 46. For an average physician "that time burden takes the physician's ability away from more than 700 patient visits per year." [49] at 10 ¶ 47. ABMS has entered into agreements with many of the specialty boards to impose even greater time and expense burdens. [49] at 11 ¶ 53. According to the complaint, the MOC program imposes greater burdens than any analogous program in any other profession. [49] at 11 ¶ 56.

Every state has one or more official medical board authorized by law and accountable to the public that is responsible for determining physicians' fitness to practice medicine. [49] at 12 ¶ 59. ABMS is not a state medical board or other state entity, but a nonprofit organization. None of the state medical boards require purchase of or participation in MOC. [49] at 12 ¶ 59. Several states, including Texas and Oklahoma, have enacted laws prohibiting the imposition of MOC as a requirement for physicians in various contexts. [49] at ¶ 60.

AAPS first brought this complaint in the District of New Jersey, alleging (1) a violation of Section 1 of the Sherman Act, 15 U.S.C. § 1, and (2) negligent misrepresentation. [1]. The court transferred the case to the Northern District of Illinois pursuant to 28 U.S.C. § 1406(a). [22]; *Ass'n of Am. Physicians & Surgeons*, 2014 WL 1334260.

ABMS moved to dismiss the complaint. [30]. The court granted ABMS's motion. [48]; *Ass'n of Am. Physicians & Surgeons*, 2017 WL 6821094. The court held that the complaint did not plausibly allege: (1) for purposes of the Sherman Act claim, an unreasonable restraint of trade (under either the *per se* rule or the rule of reason) or antitrust injury; or (2) with respect to the negligent misrepresentation claim, any false statement of fact by ABMS. [48]. The court granted AAPS leave to amend.

AAPS then filed this two-count amended complaint, (1) again bringing a claim under Section 1 of the Sherman Act and (2) instead of negligent misrepresentation, bringing a claim under the Illinois Uniform Deceptive Trade Practices Act, 815 ILCS 510/2. [49]. AAPS seeks to represent the interests of its members. [49] at 4–5 ¶ 12. It also seeks to bring claims on behalf of a class defined as "all physicians in private practice who are in-network or seek to be in-network

with health insurers or who treat or seek to treat patients in hospitals, and who are not exempt from the board certification burdens of ABMS and its above-listed Specialty Boards." [49] at 14 ¶ 72.

ABMS now moves to dismiss the amended complaint. [51].

DISCUSSION

"A motion under Rule 12(b)(6) challenges the sufficiency of the complaint to state a claim upon which relief may be granted." *Hallinan v. Fraternal Order of Police Chicago Lodge No. 7*, 570 F.3d 811, 820 (7th Cir. 2009). "[W]hen ruling on a defendant's motion to dismiss, a judge must accept as true all of the factual allegations contained in the complaint." *Erickson v. Pardus*, 551 U.S. 89, 94 (2007). A "complaint must contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. v. Twombly*, 550 U.S. 544, 570 (2007)). "Factual allegations must be enough to raise a right to relief above the speculative level." *Twombly*, 550 U.S. at 555. Mere conclusions "are not entitled to the assumption of truth." *Iqbal*, 556 U.S. at 679.

I. Sherman Act Section 1 (Count 1)

Section 1 of the Sherman Act provides: "Every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States, or with foreign nations, is declared to be illegal." 15 U.S.C. § 1. To state a claim for a Section 1 violation, the complaint must plausibly allege: (1) a contract, combination, or conspiracy (*i.e.*, an agreement), (2) a resultant unreasonable restraint of trade in a relevant market, and (3) an accompanying injury. *Agnew v. Nat'l Collegiate Athletic Ass'n*, 683 F.3d 328, 335 (7th Cir. 2012).

As discussed above, in dismissing the initial complaint, Judge Wood held that the complaint did not plausibly allege the second or third elements of a Section 1 claim: an unreasonable restraint and antitrust injury. [48]. AAPS then filed the operative amended complaint, again alleging that ABMS violated Section 1. In the motion to dismiss, ABMS argues that the amended complaint did not cure the deficiencies as to these two elements.

A. Unreasonable restraint of trade in a relevant market

On the second element, the complaint must plausibly allege an unreasonable restraint of trade in a relevant market. The parties dispute whether any alleged restraint was unreasonable. ABMS also contends that the complaint does not define a relevant market.

"[T]he determination of whether a restraint is unreasonable must focus on the competitive effects of challenged behavior relative to such alternatives as its

abandonment or a less restrictive substitute." *Agnew*, 683 F.3d at 335 (quotation marks and citations omitted). Courts use three categories of analysis to determine whether actions have anticompetitive effects: *per se*, quick-look, and rule of reason, "though the methods often blend together." *Id.* "All of these methods of analysis are meant to answer the same question: whether or not the challenged restraint enhances competition." *Id.* (citations and internal quotation marks omitted). AAPS argues ABMS's conduct is unlawful under both the *per se* and rule of reason frameworks.

Here, AAPS appears to allege two different types of restraints: (1) unlawful tying arrangements and (2) unlawful agreements to require MOC. The court addresses each type of restraint below.

1. **Tying**

AAPS alleges that "ABMS's collusion with health insurers and hospitals" is an unlawful *per se* tying of "products and services." [49] at 6 ¶ 17; *see also* [49] at 16–17 ¶¶ 86–88.

A tying arrangement is "an agreement by a party to sell one product but only on the condition that the buyer also purchases a different (or tied) product, or at least agrees that he will not purchase that product from any other supplier." *Northern Pacific R. Co. v. United States*, 356 U.S. 1, 5–6 (1958); *see also Eastman Kodak Co. v. Image Tech. Servs., Inc.*, 504 U.S. 451, 461–62 (1992); *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 11–12 (1984), *abrogated on other grounds by Illinois Tool Works Inc. v. Indep. Ink, Inc.*, 547 U.S. 28 (2006); *Viamedia, Inc. v. Comcast Corp.*, 951 F.3d 429, 468 (7th Cir. 2020). "In order to establish the per se illegality of a tying arrangement, a plaintiff must show that: (1) the tying arrangement is between two distinct products or services, (2) the defendant has sufficient economic power in the tying market to appreciably restrain free competition in the market for the tied product, and (3) a not insubstantial amount of interstate commerce is affected. . . . In addition, . . . an illegal tying arrangement will not be found where the alleged tying company has absolutely no economic interest in the sales of the tied seller, whose products are favored by the tie-in." *Reifert v. S. Cent. Wisconsin MLS Corp.*, 450 F.3d 312, 316 (7th Cir. 2006) (citations omitted) (quoting *Carl Sandburg Vill. Condo. Ass'n No. 1 v. First Condo. Dev. Co.*, 758 F.2d 203, 207 (7th Cir. 1985)).

AAPS does not allege facts that suggest a tying arrangement between two distinct products or services. AAPS cites *Talone v. Am. Ost. Ass'n*, No. 16-cv-04644, 2017 WL 2539394 (D.N.J. June 12, 2017). [55] at 8. But *Talone* involved the tying of the American Osteopathic Association's ("AOA") certification and AOA membership, *i.e.*, AOA's requiring osteopathic physicians, who were certified by AOA, to purchase AOA membership to maintain their certification. *Id.* at *5.

Here, unlike in *Talone*, the nature of the tying arrangement is not entirely clear. AAPS alleges that "ABMS's collusion with health insurers and hospitals" is an unlawful *per se* tying of "products and services." [49] at 6 ¶ 17; *see also* [49] at 16–17 ¶¶ 86–88. AAPS's response brief states that "ABMS induces insurance companies and hospitals to require or 'tie' ABMS MOC® as a condition of being in-network or on staff." [55] at 7. Later the response describes the "tying of certification" without clearly identifying to what it is tied. [55] at 8. No further allegations elaborate on the tying arrangement. It is unclear which products or services are "tying" or "tied."

The complaint may be alleging that ABMS, insurers, and hospitals are colluding to tie a product unwanted by physicians (MOC) to the provision of "services" wanted by physicians (in-network status and / or hospital privileges, if these can even be considered "services"), but if so, the complaint does not allege such a theory with sufficient clarity for the court to evaluate the claim, nor do the briefs address such a theory. *See Ellison v. Am. Bd. of Orthopaedic Surgery, Inc.*, No. 16-cv-08441, 2020 WL 1183345, at *10 (D.N.J. Mar. 12, 2020) ("A tying arrangement must be viewed in light of the power wielded by the purported seller to force a consumer to buy other products it did not want, or did not want on those terms. . . . There are no facts tending to demonstrate that *ABOS*—the defendant here—is conditioning staff privileges on participation in its certification program, or profiting therefrom. The theory, then, must be some highly attenuated one, for which the necessary facts are not pled.") (emphasis in original). The allegations do not plausibly suggest an arrangement to tie MOC and admitting privileges and / or in-network status between ABMS and a nationwide group of hospitals and / or insurance companies. Nor does the complaint attempt to resolve the "difficulties in treating hospital staff status as a tied 'product' sold in a market." *Id.*

Because the complaint does not sufficiently allege a tying arrangement between two products or services, a tying claim cannot proceed.

2. MOC requirements

Next, AAPS alleges that ABMS, the specialty boards, health insurers, and hospitals have agreed to require physicians to purchase MOC. The question is whether the complaint has plausibly alleged an unreasonable restraint of trade under the *per se* rule or the rule of reason.

a. *Per se* rule

Under the *per se* rule, certain restraints may be deemed unreasonable without any inquiry into the relevant market context. *Nat'l Collegiate Athletic Ass'n v. Bd. of Regents of Univ. of Oklahoma*, 468 U.S. 85, 100 (1984). "The *per se* rule, treating categories of restraints as necessarily illegal, eliminates the need to study the reasonableness of an individual restraint in light of the real market

forces at work . . . . Restraints that are *per se* unlawful include horizontal agreements among competitors to fix prices . . . or to divide markets . . . ." *Leegin Creative Leather Prod., Inc. v. PSKS, Inc.*, 551 U.S. 877, 886 (2007) (citations omitted). "Resort to *per se* rules is confined to restraints, like those mentioned, that would always or almost always tend to restrict competition and decrease output. . . . To justify a *per se* prohibition a restraint must have manifestly anticompetitive effects, . . . and lack . . . any redeeming virtue." *Id.* (citations and internal quotation marks omitted). "As a consequence, the *per se* rule is appropriate only after courts have had considerable experience with the type of restraint at issue, . . . and only if courts can predict with confidence that it would be invalidated in all or almost all instances under the rule of reason," rather than "in the context of business relationships where the economic impact of certain practices is not immediately obvious." *Id.* at 886–87 (citations and internal quotation marks omitted); *see also Agnew*, 683 F.3d at 336.

As Judge Wood held in dismissing the prior complaint: "AAPS has not alleged any type of agreement suggesting a *per se* unlawful restraint, such as a horizontal agreement among competitors to fix prices or to divide markets." [48] at 7. The allegations in the amended complaint do not solve this problem. There is no basis to infer that the type of restraint alleged here is one that tends to restrict competition and decrease output in all or almost all instances, nor does AAPS's response brief argue there is one. *See BCB Anesthesia Care Ltd. v. Passavant Mem. Area Hosp. Ass'n*, 36 F.3d 664, 667 (7th Cir. 1994) ("there is nothing obviously anticompetitive about a hospital choosing one staffing pattern over another or in restricting the staffing to some rather than many, or all"); *Ellison*, 2020 WL 1183345, at *7 (regarding a hospital's requiring physicians to be certified, "[i]t cannot be said that such a practice has no legitimate purpose, and can only be aimed at restraining trade"; "a hospital's requirement that physicians meet certain qualifications will rarely if ever" be "found to be *per se* unreasonable"). Nor is there any indication that courts have had considerable experience with similar alleged restraints such that a *per se* analysis would be appropriate for the alleged agreements here.

b. **Rule of reason**

Turning to the rule of reason, under that analysis, "the plaintiff carries the burden of showing that an agreement or contract has an anticompetitive effect on a given market within a given geographic area." *Agnew*, 683 F.3d at 335. "As a threshold matter, a plaintiff must show that the defendant has market power—that

is, the ability to raise prices significantly without going out of business—without which the defendant could not cause anticompetitive effects on market pricing." *Id.*

The amended complaint does not sufficiently allege a relevant market or market power within that market.

As to the relevant market, the plaintiff's "threshold burden" under the ruleof reason "involves the showing of a precise market definition in order to demonstrate that a defendant wields market power, which, by definition, means that the defendant can produce anticompetitive effects." *Agnew*, 683 F.3d at 337. "Because legal presumptions that rest on formalistic distinctions rather than actual market realities are generally disfavored in antitrust law, . . . courts usually cannot properly apply the rule of reason without an accurate definition of the relevant market. Without a definition of the market there is no way to measure the defendant's ability to lessen or destroy competition. . . . Thus, the relevant market is defined as the area of effective competition. Typically this is the arena within which significant substitution in consumption or production occurs." *Ohio v. Am. Express Co.*, 138 S. Ct. 2274, 2285 (2018) (citations, internal quotation marks, brackets, and footnote omitted). "The antitrust statutes require a pragmatic and factual approach to defining the geographic market. . . . The market must correspond to the commercial realities of the industry." *Sharif Pharmacy, Inc. v. Prime Therapeutics, LLC*, 950 F.3d 911, 917 (7th Cir. 2020) (citations and internal quotation marks omitted); *see also 42nd Parallel North v. E Street Denim Co.*, 286 F.3d 401, 406 (7th Cir. 2002).

The original complaint alleged that the relevant market consisted of "medical care provided by physicians to hospitalized patients." [1] at 4 ¶ 8. The amended complaint defines the relevant market as follows: "The relevant service market consists of medical care provided by physicians who are subject to MOC, and who are either in-network, or seek to be in-network, with health insurers, or treat or seek to treat hospitalized patients." [49] at 13 ¶ 67. "The relevant geographic market is nationwide except for States that have generally prohibited MOC requirements, as Texas has." [49] at 13 ¶ 68.

The market definition in the amended complaint does not plausibly "correspond to the commercial realities" of the relevant industry. *Sharif Pharmacy*, 950 F.3d at 917. "It is true that in most cases, proper market definition can be determined only after a factual inquiry into the commercial realities faced by consumers. Plaintiffs err, however, when they try to turn this general rule into a *per se* prohibition against dismissal of antitrust claims for failure to plead a relevant market under Fed. R. Civ. P. 12(b)(6)." *Queen City Pizza, Inc. v. Domino's Pizza, Inc.*, 124 F.3d 430, 436 (3d Cir. 1997); *see also Little Rock Cardiology Clinic PA v. Baptist Health*, 591 F.3d 591, 601 (8th Cir. 2009) (affirming dismissal for failure to plead plausible relevant market); *Chapman v. New York State Div. for Youth*, 546 F.3d 230, 238 (2d Cir. 2008) (same).

Again, the relevant market is "the area of effective competition," which is generally the "arena within which significant substitution in consumption or production occurs." *Ohio*, 138 S. Ct. at 2285 (citations and internal quotation marks omitted). The amended complaint does not allege facts that plausibly suggest that consumers distinguish between physicians who are subject to MOC and those who are not. Likewise for the definition's geographic scope, which is "nationwide except for States that have generally prohibited MOC requirements, as Texas has." [49] at 13 ¶ 68. "For highly exotic or highly elective hospital treatment, patients will sometimes travel long distances, of course. But for the most part hospital services are local. People want to be hospitalized near their families and homes, in hospitals in which their own—local—doctors have hospital privileges." *United States v. Rockford Mem'l Corp.*, 898 F.2d 1278, 1284–85 (7th Cir. 1990).[3] The same is true of the outpatient care encompassed in the proposed market definition. Further, even if consumers were willing to travel across the country for substitute medical care, the complaint offers no reason why they would only go to states that allow MOC requirements. The complaint provides no reason why these limitations accurately reflect commercial realities.

Even if this definition plausibly described a market, the complaint does not plausibly suggest market power in that market. "Substantial market power is an essential ingredient of every antitrust case under the Rule of Reason." *Sanjuan v. Am. Bd. of Psychiatry & Neurology, Inc.*, 40 F.3d 247, 251 (7th Cir. 1994), *as amended on denial of reh'g* (Jan. 11, 1995).

Even assuming that it would be appropriate to consider the market power of not just ABMS but also the specialty boards, health insurers, and hospitals, in order to have market power in the relevant market, ABMS and the specialty boards, health insurers, and hospitals would need to be able to raise the prices of physician care—effectively in a nationwide market—without going out of business. The amended complaint asserts, without elaboration, that health insurers and hospitals themselves have sufficient market power. [49] at 6–7 ¶¶ 18, 25; *id.* at 16 ¶ 86. AAPS further states in its brief:

> There is no lack of market power by any entity on Defendant's side of this case. The aggregate market power of the American Hospital Association and the Blue Cross and Blue Shield Association, through their members, cannot seriously be doubted. Each hospital almost always has market power in its community, as do insurance companies within their respective States. Through their trade associations they

[3] AAPS argues that "[e]ach hospital almost always has market power in its community, as do insurance companies within their respective States." [55] at 9–10. Even if AAPS could proceed on a theory that ABMS conspired with entities nationwide to restrain trade in most or all localized markets for physician care, this conclusory statement about market power is far too general to support AAPS's proposed market definition.

> have market power in the relevant market of medical services provided at hospitals or through insurance networks.

[55] at 9–10. AAPS does not elaborate on these conclusory allegations, nor does AAPS provide any facts substantiating the alleged market share belonging to the American Hospital Association, the Blue Cross and Blue Shield Association, or any other participant in the alleged market. Without some assertion of the relevant market size and the power wielded by the alleged co-conspirators, there are no facts to support ABMS's alleged market power (with or without the agreements alleged in the complaint). *See Sheridan v. Marathon Petroleum Co. LLC*, 530 F.3d 590, 595 (7th Cir. 2008) ("[U]nder the pleading regime created by [*Twombly*], the plaintiffs' naked assertion of Marathon's "appreciable economic power"—an empty phrase—cannot save the complaint.").

Because the complaint does not sufficiently allege either a relevant market or market power within that market, it does not state a Section 1 claim under the rule of reason.

B. Agreement

The parties dispute not only whether any restraint was unreasonable (discussed above) but also whether ABMS imposed *any* restraint at all. The dispute concerns the second element of a Section 1 claim (restraint), but AAPS's arguments on the issue undermine the first element (agreement).

Judge Wood held in dismissing the original complaint: "AAPS has alleged no facts showing that ABMS has the ability to control hospitals nationwide or coerce hospitals to force physicians to participate in the MOC program" and "AAPS has not pleaded facts plausibly suggesting that ABMS has authority over any insurance companies sufficient to cause a restraint of trade." [48] at 8, 9 n.2. This is true of the amended complaint as well; there are no facts that plausibly suggest ABMS possesses authority or control over hospitals or insurers.

Consistent with Judge Wood's holding, ABMS argues in the motion to dismiss that ABMS lacks control or authority over insurers and hospitals and thus could not have restrained trade. [52] at 8–10; [56] at 6–7. *See Schachar v. American Academy of Ophthalmology*, 870 F.2d 397, 399 (7th Cir. 1989) (no restraint where defendant had "no authority over hospitals, insurers, state medical societies or licensing boards"); *Marrese v. Am. Acad. of Orthopaedic Surgeons*, 977 F.2d 585, at *7 (7th Cir. 1992); *Patel v. American Board of Psychiatry & Neurology, Inc.*, No. 89-cv-01751, 1989 WL 152816, at *3 (N.D. Ill. Nov. 21, 1989); *Oral Implantology*, 390 F. Supp. 3d at 906 ("If the certifying entity lacks the power to prevent (or has not

prevented) the professional from practicing without a certification, there has been no antitrust violation").[4]

In response to this argument, AAPS clarifies that it is alleging that the specialty boards, hospitals, and health insurers are co-conspirators, and disclaims any allegation that ABMS exerted control over those entities. *See* AAPS Resp., [55] at 5 ("AAPS does not allege that ABMS has forced insurance companies or hospitals to do anything, but rather that ABMS has conspired and colluded with insurance companies and hospitals"). The amended complaint alleges: "ABMS has conspired with health insurers and hospitals to require physicians to purchase the ABMS MOC® product as a condition of being in health plan networks or having medical staff privileges, respectively." [49] at 6 ¶ 16. With the restraint of trade framed this way, the fact that ABMS lacks authority or control over its coconspirators does not itself decide whether the alleged coconspirators together restrained trade.

However, as ABMS points out in its reply brief, this new framing only works if AAPS has plausibly alleged such a conspiracy. *See* [56] at 6–7.[5] Indeed, Section 1 does not prohibit all unreasonable restraints on trade, but only those effected by a contract, combination, or conspiracy, in other words, by an agreement. *Twombly*, 550 U.S. at 553. To allege a conspiracy or agreement, AAPS must allege that ABMS "had a conscious commitment to a common scheme designed to achieve an unlawful objective." *Omnicare, Inc. v. UnitedHealth Group, Inc.*, 629 F.3d 697, 706 (7th Cir. 2011) (quoting *Monsanto Co. v. Spray–Rite Serv. Corp.*, 465 U.S. 752, 764 (1984)). "That is, the circumstances of the case must reveal 'a unity of purpose or a common design and understanding, or a meeting of minds in an unlawful arrangement.'" *Omnicare*, 629 F.3d at 706 (quoting *Am. Tobacco Co. v. United States*, 328 U.S. 781, 810 (1946)).

The allegations in the amended complaint do not plausibly allege a nationwide agreement between ABMS and an untold number of hospitals and health insurers. Yet again, the problem stems from the proposed market definition. As noted above, that definition is as follows: "The relevant service market consists of medical care provided by physicians who are subject to MOC, and who are either in-network, or seek to be in-network, with health insurers, or treat or seek to treat hospitalized patients." [49] at 13 ¶ 67. "The relevant geographic market is nationwide except for States that have generally prohibited MOC requirements,

[4] The opinion in *Oral Implantology* was issued after the parties finished briefing this motion but involves a similar analysis about the lack of restraint in the professional certification context.

[5] ABMS did not directly challenge the allegations supporting the alleged agreement until its reply brief. However, AAPS addressed the alleged conspiracy in its response brief, so it is appropriate to reach the issue. *See Carver v. Nall*, 172 F.3d 513, 515 (7th Cir. 1999) ("specifically address[ing]" point in response brief not raised in opening constitutes waiver of forfeiture argument).

as Texas has." [49] at 13 ¶ 68. The proposed market appears to encompass a substantial number, if not the vast majority, of physicians nationwide (with the exceptions of Texas, Oklahoma, and perhaps other unspecified states) who are subject to MOC and who treat patients in typical, common settings, such as hospitals and clinics. The sweeping breadth of the alleged market and the sheer number of hospitals and insurance companies that would have to be involved make the alleged agreement implausible. *See Ellison*, 2020 WL 1183345, at *8 (illegal agreement between American Board of Orthopaedic Surgery and "large collection of New Jersey hospitals" implausible).

The other relevant allegations in the amended complaint do not make the claim plausible. Some allegations describe the widespread adoption by insurers and hospitals of MOC as a requirement for physicians. The complaint alleges that "Blue Cross and Blue Shield-affiliated health plans in multiple states," such as Blue Cross and Blue Shield of Massachusetts and Independence Blue Cross of Pennsylvania, "impose a requirement that physicians purchase and participate in ABMS MOC® as a condition of participating in their health insurance networks." [49] at 6–7 ¶¶ 19–22. The complaint further alleges that "[a]pproximately 80% of hospitals now require certification by ABMS as a condition for physicians to be on the medical staff," [49] at 8 ¶ 31, and "[m]ost health insurers, particularly in metropolitan areas, require that physicians purchase and comply with Defendant's ABMS MOC® product as a condition of being in-network with the insurer," [49] at 7 ¶ 24. Additionally, the AHA (a hospital trade association) "is an associate member of Defendant ABMS and agrees with it to impose ABMS MOC® on physicians." [49] at 7 ¶ 26. However, "an allegation of parallel conduct and a bare assertion of conspiracy will not suffice." *Twombly*, 550 U.S. at 556; *see also Ellison*, 2020 WL 1183345, at *7–8 ("Without more, the mere fact that certain hospitals require Board Certification for admitting privileges combined with a bare assertion that hospitals conspired with ABOS is not a sufficient allegation of an unlawful agreement. . . . Nothing in this complaint goes beyond an allegation that the hospitals chose to require certification by an outside organization, ABOS.").

Other than the allegations of widespread adoption of MOC as a physician requirement (which are not sufficient as discussed above), there are no plausible factual allegations about how ABMS entered into an arrangement with hospitals and insurers throughout the country, nor why it would make sense for these diverse entities to do so. ABMS allegedly "publicly admits that it encouraged and obtained a commitment by the Blue Cross and Blue Shield Association ('BCBSA') to require physicians to purchase and participate in ABMS MOC® as a condition of physicians being in-network with health insurance plans," causing "Blue Cross and Blue Shield-affiliated health plans in multiple states," such as Blue Cross and Blue Shield of Massachusetts and Independence Blue Cross of Pennsylvania, to impose such a requirement. [49] at 6 ¶¶ 19–22. And ABMS has referenced its "campaign to induce hospitals to impose the ABMS MOC® product as a condition of holding medical staff privileges." [49] at 7–8 ¶ 27. Encouraging and campaigning for MOC

adoption are not the same as a conspiracy, and nothing suggests BCBSA did not independently decide to require MOC. *See Ellison*, 2020 WL 1183345, at *8 ("These vague allegations that ABMS influenced or pressured hospitals into requiring board certification actually suggest just the opposite. Lacking any actual agreement with hospitals, ABMS engaged in public marketing efforts in an attempt to expand the reach of its programs."). And even if these allegations plausibly suggested an agreement with Blue Cross and Blue Shield-affiliated health plans in particular (which they do not), they still would not plausibly suggest a nationwide agreement between insurers, hospitals, and ABMS. The complaint also offers no explanation for why hospitals and insurers would enter into an agreement that allegedly reduces the output and increases the cost of physician care just to benefit ABMS.

Moreover, there is an alternative explanation for hospitals and insurers to require MOC aside from an unlawful agreement—that hospitals and insurers independently decided MOC provides useful information. *See Ellison*, 2020 WL 1183345, at *8 ("the 2AC asserts nothing to suggest that this large collection of New Jersey hospitals decided to require board certification as a prerequisite to medical staff privileges based on an illicit agreement, rather than as the result of their own independent calculation that this requirement would improve the quality of care or make them more competitive in attracting patients"). In light of this alternative, the allegations do not plausibly suggest an agreement to restrain trade. *See Twombly*, 550 U.S. at 567–69; *Iqbal*, 556 U.S. at 682. At best, the complaint alleges facts that are "merely consistent with" a conspiracy, and that is not enough. *Twombly*, 550 U.S. at 557; *see also Ellison*, 2020 WL 1183345, at *7–8.

For these reasons, to the extent the amended complaint has alleged a restraint on trade, it has not alleged one effected by a conspiracy.

Since the amended complaint plausibly alleges neither an unreasonable restraint of trade in a relevant market nor an agreement in the first place, the court need not address whether the complaint plausibly alleges an antitrust injury. Count 1 is dismissed.

II. Illinois Uniform Deceptive Trade Practices Act (Count 2)

In the original complaint, AAPS asserted a negligent misrepresentation claim. Judge Wood granted ABMS's motion to dismiss that claim. *See* [48] at 12–13.

Instead of negligent misrepresentation, Count 2 of the amended complaint asserts a claim under the Illinois Uniform Deceptive Trade Practices Act, 815 ILCS 510/2. [49] at 18–22 ¶¶ 97–121.

> The Act provides as relevant:
>
> (a) A person engages in a deceptive trade practice when, in the course of his or her business, vocation, or occupation, the person: . . . (8) disparages the goods, services, or business of another by false or misleading representation of fact . . . .

815 ILCS 510/2(a)(8); *see ATC Healthcare Services, Inc. v. RCM Technology*, 192 F. Supp. 3d 943, 952 (N.D. Ill. 2016); *Menasha Corp. v. News Am. Mktg. In–Store, Inc.*, 238 F. Supp. 2d 1024, 1035 (N.D. Ill. 2003). A plaintiff must identify some form of communication to the public regarding the plaintiff's services that is "false, misleading, or deceptive." *Lynch Ford, Inc. v. Ford Motor Co.*, 957 F. Supp. 142, 147 (N.D. Ill. 1997); *see also Associated Underwriters of America Agency, Inc. v. McCarthy*, 356 Ill. App. 3d 1010, 1021, 826 N.E.2d 1160, 1169 (2005) ("In its complaint and on appeal, plaintiff is unable to point to any *specific* communication by defendants that disparaged plaintiff's business.") (emphasis added).

In holding that the complaint did not state a negligent misrepresentation claim, Judge Wood held that many of ABMS's representations were "simply true statements." [48] at 12–13. Abandoning its previous argument that ABMS made *false* statements of fact, AAPS now contends that ABMS's representations are misleading. AAPS focuses its argument on two words: "board" and "requirements." Specifically, AAPS argues that "ABMS calling itself a 'Board' while referring to its arbitrary conditions as 'requirements' is misleading and unfair." [55] at 14. "Board," according to AAPS, misleadingly implies that ABMS "has some authority akin to an official state medical board, when in fact Defendant and its co-conspirators lack any official legitimacy." [49] at 20 ¶ 110. The amended complaint does not plausibly allege how an ordinary person would infer "official state authority" upon hearing "board." Boards come in a variety of forms and are not always official state government entities. The argument with respect to "requirements" fares no better. Under this theory, the use of the word "requirements" misleadingly connotes a "legal, governmental, or academic requirement or oversight." [49] at 18 ¶ 102. The amended complaint does not plausibly allege that "requirements" implies such oversight, particularly when many "requirements" without a formal legal, governmental, or academic mandate exist.

Finally, AAPS's general allegations about ABMS, *e.g.*, [49] at 19 ¶¶ 105, 107, do not plausibly allege communications about an identifiable good or service. *See Associated Underwriters*, 826 N.E.2d at 1169; *Maui Jim, Inc. v. SmartBuy Guru Enterprises*, 386 F. Supp. 3d 926, 939 (N.D. Ill. 2019) ("under the UDTPA a plaintiff must allege that defendant published untrue or misleading statements that disparaged the plaintiff's goods or services") (citation omitted). Count 2 is dismissed.

CONCLUSION

The motion to dismiss [51] is granted. The amended complaint is dismissed with prejudice.

Date: September 22, 2020 /s/ Martha M. Pacold

IN THE UNITED STATES DISTRICT COURT
FOR THE
NORTHERN DISTRICT OF ILLINOIS

Association of American Physicians & Surgeons, Inc., Plaintiff(s), v. American Board of Medical Specialties, Defendant(s).	Case No. 14 C 2705 Judge Martha M. Pacold

JUDGMENT IN A CIVIL CASE

Judgment is hereby entered (check appropriate box):

☐ in favor of plaintiff(s)
and against defendant(s)
in the amount of $,

which ☐ includes pre–judgment interest.
☐ does not include pre–judgment interest.

Post-judgment interest accrues on that amount at the rate provided by law from the date of this judgment.

Plaintiff(s) shall recover costs from defendant(s).

☐ in favor of defendant(s)
and against plaintiff(s)

.

Defendant(s) shall recover costs from plaintiff(s).

☒ other: Judgment is entered in favor of Defendant American Board of Medical Specialties and against Plaintiff Association of American Physicians & Surgeons, Inc.

This action was *(check one)*:

☐ tried by a jury with Judge presiding, and the jury has rendered a verdict.
☐ tried by Judge without a jury and the above decision was reached.
☒ decided by Judge Martha M. Pacold on a motion to dismiss.

Date: 9/22/2020

Thomas G. Bruton, Clerk of Court

/s/ Ruth O'Shea, Deputy Clerk