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.

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

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SUMMARY OF REPLY ARGUMENT

The American Board of Medical Specialties (ABMS) devotes most of its appellee brief to asserting facts found nowhere in the record, and irrelevant to the existence of causes of action here. A substantial portion of its brief focuses on issues not decided below, which are not ripe to address for the first time on appeal. In addition, ABMS misplaces reliance on factual assertions contained in other district court decisions which were decided on pleadings without ever allowing factual development.

As adequately alleged below by the Association of American Physicians & Surgeons (AAPS), physicians are excluded from hospitals and insurance networks if they do not purchase and comply with ABMS's Maintenance of Certification® (MOC). ABMS insists, without basis in the record, that it is merely the fortunate beneficiary of requirements by others to purchase its product. But there is much in the pleading which sets forth, as one would expect, that ABMS plays an active role in having others require the purchase of its product. At this pre-discovery stage of the litigation, a plaintiff need not and typically cannot allege a specific unlawful agreement to restrain trade. Smoking guns are found through discovery, not on public websites.

By insisting on dismissal without discovery, ABMS implicitly seeks a special exemption from the Sherman Act available only to the lucky few like Major League Baseball. As a commercial entity having no accountability to government, customers, or the public, ABMS is not entitled to an exemption from judicial review of how it

compels purchase of its unwanted product. The *Journal of the American Medical Association* observed that "[t]he 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." (AAPS Br. 4; Am. Comp. ¶ 5) It is as though Major League Baseball were given an antitrust exemption *and* people were required to purchase tickets to attend MLB games. Nothing in the Sherman Act condones such a result for any commercial product or entity, including ABMS.

Implausibly, ABMS declares that "[e]very statement that ABMS has made about MOC has been made on its website or otherwise announced publicly." (ABMS Br. 44) Its assertion cannot possibly be true, as ABMS does not publicize everything it says and does about MOC. This Court should not accept this and other factual claims by ABMS without allowing AAPS to test their veracity in discovery. ABMS also mischaracterizes the pleading by pretending that it describes MOC as "entirely voluntary." (ABMS Br. 17) To the contrary, AAPS alleges in detail how ABMS's product is not "entirely" voluntary and, even if it were, there is no exemption in the Sherman Act for voluntary commercial products sold through a restraint of trade. ABMS further relies heavily on an extra-jurisdictional district court decision for which an appeal is currently pending to the Third Circuit, without alerting this Court to the pendency of that appeal in which ABMS has itself participated by filing an amicus brief. *Ellison v. Am. Bd. of Orthopaedic Surgery, Inc.*, No. 16-8441 (KM) (JBC), 2020 U.S. Dist. LEXIS 43993 (D.N.J. Mar. 12, 2020),

appeal pending, Third Circuit No. 20-1776 (oral argument held on April 12, 2021) (cited by ABMS Br. 3, 4, 18, 20, 21, 22, 24, 35). Meanwhile, ABMS fails to distinguish multiple precedents of this Court as cited by AAPS in its opening brief.[1]

When conduct compelling purchase of a proprietary product restrains trade so perniciously that state legislatures then prohibit entities from requiring it, judicial review of the restraint of trade is warranted. Yet ABMS says little in its brief about how some state legislatures, most notably Texas, have banned the requirement of its unwanted product. Determining whether the target of the state legislation – ABMS's restraint of trade – constitutes an antitrust violation under federal law requires development of a factual record, which should not be foreclosed based on speculation about plausibility or factual assertions by the defendant from outside of the record.

ABMS argues that AAPS does not have standing to obtain damages on behalf of its members, but AAPS primarily seeks injunctive relief and ABMS does not dispute standing by AAPS for that. The amount of the injury suffered by AAPS members may vary among them, but their common right to injunctive relief does not. Moreover, because this was not an issue reached by the lower court, at most this argument by ABMS should be raised after a remand for a decision there in the first instance.

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[1] For example, although cited multiple times in AAPS's opening brief, ABMS makes no mention of *Levin v. Miller*, 763 F.3d 667 (7th Cir. 2014), and *Sheridan v. Marathon Petroleum Co. LLC*, 530 F.3d 590 (7th Cir. 2008).

ABMS prematurely argues against antitrust injury, an issue also not reached by the dispositive decision below. AAPS's allegations describe a reduction in output due to ABMS's unwanted restraint of trade. Medical services are highly personal and not fungible as widgets or gasoline are, and antitrust injury occurs when patients are denied access to (or insurance reimbursement for) their preferred physicians. When a patient is hospitalized and cannot be seen by the patient's own physician due to an MOC restraint, then that is an injury to the market which the Sherman Act prohibits. This issue is also not for resolution in the first instance on appeal, but should be addressed by the district court after development of a factual record.

Finally, it remains a disputed issue of material fact not be resolved on a motion to dismiss whether the moniker "Not Meeting MOC Requirements" is a misleading disparagement of physicians who do not or cannot purchase and comply with ABMS's MOC program. ABMS never responded to the argument that, for example, the smartphone manufacturer Apple could not properly disparage individuals who decline to pay Apple, by announcing publicly that they are "Not Meeting iPhone Requirements." The Amended Complaint states a cause of action for unfair business practices by ABMS under Illinois law, a cause of action suggested in a general way by Judge Easterbrook in a decision upon which ABMS relies. *See* Point V, *infra.*

As explained further below, the district court decision should be reversed.

REPLY ARGUMENT

ABMS fails to explain why this case should be dismissed with prejudice with the effect that no factual development is allowed on its widely criticized restraint of trade, thereby giving ABMS free rein to arrange for other entities to require the purchase of its product. ABMS interferes with access by patients to their preferred physicians in hospitals and in insurance networks, and yet ABMS never squarely addresses the harm this causes. Instead, ABMS seems to argue everything other than the central issue, and much of its brief consists of its own factual assertions found nowhere in the Amended Complaint.

AAPS's opening brief and its allegations in the Amended Complaint require reversal of the premature dismissal below by the district court. As shown next, none of ABMS's arguments in its brief here has merit.

I. ABMS's Factual Arguments Are Misplaced on Its Motion to Dismiss.

ABMS's MOC® is a widely criticized money-making program for ABMS. (Am. Compl., Dkt. #49, ¶¶ 1, 4-5, 58) Yet rather than address this, ABMS resorts in its brief to making factual assertions about its MOC program which are nowhere in the pleading, and thus should not be considered, on this appeal from a grant of a Rule 12(b)(6) motion to dismiss. *See, e.g.*, *Alamo v. Bliss*, 864 F.3d 541, 548-49 (7th Cir. 2017) ("In our review, we must 'accept as true all factual allegations in the amended complaint and draw all permissible inferences in [the plaintiff]'s favor.'") (quoting *Bible v. United*

Student Aid Funds, Inc., 799 F.3d 633, 639 (7th Cir. 2015)). Similarly, ABMS cannot circumvent this rule by citing district court decisions which assumed factual assertions without making factual findings. In a circular manner, for example, ABMS improperly relies on a district court statement for its own assertion that its motivation for selling the MOC product is "in response to public criticism that it was wrong to certify a physician without periodic reevaluation of the physician's knowledge and skills over time." (ABMS Br. 4, citing Dkt. #48 at 2, which merely repeated ABMS's own self-serving assertions and accepted them as true without allowing any factual development).

Discovery is needed in order to test the veracity and completeness of ABMS's own factual assertions, before this Court or any court relies on them.

A. The MOC® Program Involves a Restraint of Trade.

ABMS insists that an "indisputable fact is that plaintiff has not alleged, and cannot allege, a restraint imposed by ABMS." (ABMS Br. 17) AAPS certainly has alleged a restraint of trade by ABMS. For example, AAPS expressly alleged that "Defendant ABMS's collusion with health insurers and hospitals, as alleged in further detail below, constitutes an illegal agreement in restraint of a trade and an illegal 'tying' of products and services under the Sherman Act." (Am. Compl., Dkt. #49, ¶ 17) The interference with access by patients to their preferred physicians based on imposition of a proprietary certification product by ABMS is a restraint of trade. Whether that

restraint of trade can be justified by ABMS requires factual development, and cannot be properly resolved on a motion to dismiss.

ABMS falsely asserts that "the Amended Complaint confirms that the MOC program is entirely voluntary." (*Id.*) In fact, AAPS expressly alleges the opposite: "Defendant 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." (Am. Compl., Dkt. #49, ¶ 16) This requirement is not "voluntary". It is irrelevant to the Sherman Act that some physicians choose not comply, or that ABMS does not "force" health insurers and hospitals in some way. (ABMS Br. 17) The scope of the Sherman Act is not narrowly limited as ABMS pretends, whereby only forced conduct under threat of draconian penalties would be prohibited.

ABMS cites only two appellate decisions for its odd denial that it restrains trade, both of which stand against ABMS. In *Schachar*, the issue was merely a press release by a medical society rather than a restraint of trade. *Schachar v. Am. Acad. of Ophthalmology, Inc.*, 870 F.2d 397 (7th Cir. 1989) (cited by ABMS Br. 12, 17, 20). The challenge in that case was to a description by the defendant of radial keratotomy as being merely "experimental." In rejecting that challenge, this Court held that the dispute had nothing to do with antitrust law. "The Sherman Act is not a code of medical ethics or methodology, and whether radial keratotomy *is* 'experimental' is a medical rather than

a legal question." *Id.* at 400 (emphasis and quotations in original). The *Schachar* decision was based on how the defendant there "did not induce hospitals to withhold permission to perform the procedure, or insurers to withhold payment." *Id.* at 398. In contrast, here ABMS does induce hospitals to deny privileges to physicians who have not purchased ABMS's product, and insurers to withhold payment from them. "ABMS itself covertly colludes with hospitals and insurers to impose its proprietary product." (Am. Compl., Dkt. #49, ¶ 3) ABMS is not merely providing information, as the defendant was doing in *Schachar*; instead, ABMS has colluded and agreed with others to require its product, which the *Schachar* decision in no way condones. 870 F.2d at 399.

The other appellate decision on which ABMS relies is also unhelpful to it. *See Sanjuan v. Am. Bd. of Psychiatry & Neurology*, 40 F.3d 247, 251 (7th Cir. 1994) (cited by ABMS Br. 19, 27) In *Sanjuan*, psychiatrists failed a board certification exam and signed releases waiving their right to sue. Subsequently they did sue, and tacked on an antitrust claim. "What sinks plaintiffs' antitrust claim is not the skimpiness of their complaint but the information they provided in response to the district judge's probing." *Id.* at 251. Here there was no such probing; the allegations in the Amended Complaint were not accepted as true on the Rule 12(b)(6) motion, and inferences were not drawn in favor of Plaintiff AAPS. Instead, inferences were erroneously drawn in favor of Defendant ABMS.

ABMS further relies, inappropriately, on district court decisions for purported findings of fact despite how no factual development occurred in those cases. *See, e.g.*, *Siva v. Am. Bd. of Radiology*, No. 19 C 1407, 2021 U.S. Dist. LEXIS 3806 (N.D. Ill. Jan. 8, 2021) (decided on a motion to dismiss, yet heavily relied upon by ABMS Br. 3, 26, 34)

Finally, ABMS resorts to going outside of the record to reference federal law having no relevance here. (ABMS Br. 19) ABMS seeks an inference in its favor, which is impermissible on its Rule 12(b)(6) motion to dismiss, that the "intent" of Congress was to endorse its product and thereby legitimize it.[2] Instead, such insertions into a federal statute are the result of expensive lobbying efforts, as easily confirmed by a search on a website such as OpenSecrets.org.[3] At this stage where all inferences should be drawn in favor of AAPS, the success of expensive lobbying by ABMS in Washington, D.C., does not support its assertion of innocence as hospitals and insurance networks require purchase of ABMS's product. Far from implying that ABMS is not colluding behind the scenes, its inclusion into a federal statute suggests that it is very savvy in advancing its own commercial interests. Just as ABMS has lobbyists in D.C. to advance its scheme there, ABMS is surely making substantial efforts to induce the mandating of

[2] "That is why Congress has …." (ABMS Br. 12) It is unpersuasive for ABMS to speculate about why Congress did something, without mentioning ABMS's own extensive efforts to lobby Congress for ABMS's own commercial interests.

[3] An easy search on the prominent "OpenSecrets" website reveals that ABMS has spent far more than $100,000 on a D.C.-area lobbying firm since 2008. https://www.opensecrets.org/federal-lobbying/ (viewed 4/18/21).

purchase of its product by hospitals and insurance companies. For that inducement there are no laws requiring disclosure as there is for lobbying activity, and thus discovery is necessary to ferret out the truth.

B. ABMS Engaged in a Conspiracy.

Relying heavily on a district court decision which dismissed a pleading prior to factual development, ABMS insists that it has not engaged in a conspiracy in restraint of trade. (ABMS Br. 20-23, relying on *Ellison v. Am. Bd. of Orthopaedic Surgery, Inc.*, which is pending on appeal as noted *supra*).

ABMS presents itself as merely a lucky beneficiary of the equivalent of manna from heaven, and argues that others are requiring purchase of its product without any inducement by ABMS. If so, then that would become readily apparent in discovery as ABMS would simply respond to questions about its MOC-related arrangements with its member the American Hospital Association, to which nearly all hospitals belong, with answers indicating that no such responsive information exists. (Am. Compl., Dkt. #49, ¶ 26) But as ABMS's own public statements demonstrate, it does have arrangements with the AHA for hospitals to promote ABMS's products. (*Id.* ¶¶ 25-31) Similarly, public information suggests that ABMS has arrangements with insurers also for mandating ABMS's proprietary product. (*Id.* ¶¶ 18-24)

ABMS ignores these factual allegations, but that does not make them go away. Instead ABMS resorts to pure speculation about why others are requiring its products.

ABMS argues, for example, that "there is no reason that insurers or hospitals would conspire with ABMS to raise the cost of care." (ABMS Br. 23) There are, in fact, plausible reasons why insurers and hospitals would limit access to their networks and medical staffs. One obvious possibility is a pecuniary benefit to the insurers and hospitals for doing so. Or there may be a pecuniary benefit to the trade associations, including the American Hospital Association, for this arrangement. Alternatively, insurers and hospitals could simply be misled by ABMS about its product, which has no proven connection with the quality of care. (Am. Compl., Dkt. #49, ¶¶ 5, 58, 109) If "insurers would pay more if prices were increased," as ABMS asserts (ABMS Br. 23), then insurers could surely pass those higher costs (and more) onto consumers in the form of premium increases. As to ABMS's assertion in its brief that "hospital revenues would fall if output were reduced" (*id.* 23), that says nothing about profits. Most restraints of trade reduce output and potentially reduce revenue, but of course are done in order to increase profits. ABMS's unsupported assertion that "a conspiracy is implausible on its face" is simply wrong as a matter of basic economics, and discovery is necessary before drawing fact-based conclusions.

C. The Issue of Whether MOC Promotes Competition Is Not Before This Court.

ABMS argues extensively in defense of its product by insisting that it somehow promotes competition. (ABMS Br. 23-26) But there was no such factual finding below; nor could there properly be one on a Rule 12(b)(6) motion to dismiss. It is improper

here for ABMS to seek a factual finding on appeal as to whether MOC promotes competition without anything in the record to support such a finding. ABMS is not Major League Baseball, for which the Supreme Court has granted an exemption from application of the Sherman Act. Rather, ABMS is a commercial entity that must be fully accountable under the Sherman Act just as virtually any other commercial entity is.

Baseless speculation is not within the province of courts of law, and ABMS's attempt to obtain a ruling here that its much-criticized MOC is somehow pro-competitive should be flatly rejected.

D. ABMS Has Market Power.

ABMS argues that it lacks the market power necessary to effectuate a restraint of trade. (ABMS Br. 26-31) This, too, is an issue of fact that requires discovery before properly resolving it. Moreover, as ABMS recognizes, an allegation of market power is generally necessary only under the rule of reason test; market power need not be alleged or proven for most *per se* violations, as alleged in this case (Am. Compl., Dkt. #49, ¶ 87). *See, e.g.*, *Hardy v. City Optical*, 39 F.3d 765, 767 (7th Cir. 1994).[4]

[4] In its opening brief here, AAPS devoted an entire section to its adequate allegation of market power (AAPS Br. 28-33), but ABMS responds by arguing that AAPS has somehow waived this issue. (ABMS Br. 28 & n.2) There is no waiver by AAPS, which explained in its opening brief that "market power exists for the proprietary ABMS MOC® product, on which ABMS holds a monopoly and 80% of hospitals require it." (AAPS Br. 30) ABMS is nationwide in the sale of its product, the American Hospital Association is nationwide in facilitating the imposition of it, and the health care market is nationwide with respect to treatment and elective procedures.

Plaintiff AAPS expressly alleged that 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." (Am. Compl., Dkt. #49, ¶ 67) This is a straightforward definition of a reasonable market in which ABMS's product interferes. ABMS complains that this market includes hundreds of thousands of physicians and many thousands of other entities (ABMS Br. 27), but there is no numeric limit on the size of a relevant market that would take it outside of the scope of the Sherman Act. This Court has affirmed a finding by a district court of "the relevant market to be the provision of health care services to the American public nationwide." *Wilk v. American Med. Ass'n*, 895 F.2d 352, 360 (7th Cir. 1990) (cited favorably by Judge Easterbrook in *Schachar*, 870 F.2d at 399).

Indeed, the *Wilk v. American Med. Ass'n* decision by this Court precludes the argument by ABMS that no one could have market power in the alleged relevant market. (ABMS Br. 28) In *Wilk*, the American Medical Association was found to have violated the Sherman Act by taking actions which resulted in the exclusion of chiropractors nationwide. Here, ABMS violates the Sherman Act by taking actions which result in the exclusion of physicians nationwide who do not purchase its MOC product. Conceptually the *Wilk* decision and this case are indistinguishable, and in *Wilk* the relevant market was defined and upheld as the nationwide delivery of health care

services. *Wilk*, 895 F.2d at 360. The market power by the AMA over that relevant market was analogous to the market power by ABMS over nearly the same relevant market here. If anything, the relevant market in *Wilk* was broader than the relevant market here, which is narrowed by connection to MOC. Moreover, the connection by the AMA to the relevant market was more tenuous than the stronger connection here by ABMS through its certification requirement. In its brief ABMS argues against even the possibility of "*anyone*" having market power in the nationwide health care services market (ABMS Br. 28, emphasis in its brief), but ABMS's same counsel handled the *Wilk* case and that decision precludes ABMS's argument here.

Ultimately ABMS argues for too narrow of a scope for the Sherman Act, limiting it to the "'ability to raise prices [in the market] significantly without going out of business.'" (ABMS Br. 27, quoting *Agnew v. NCAA*, 683 F.3d 328, 335 (7th Cir. 2012)). This case here is not about pricing, but about improper arrangements to require certification and thereby reduce output. Moreover, the decision in *Agnew* relied on its view that the Supreme Court had "blessed" NCAA rules and thereby insulated them from antitrust scrutiny. *Id.* at 341. At any rate, because hospitals and insurers require ABMS's product, it is self-evident that ABMS could significantly raise the prices on its product without going out of business, thereby satisfying the test in *Agnew*.

Ironically, ABMS repeatedly cites its (lobbying-induced) inclusion in a federal statute to puff up its own significance (ABMS Br. 1, 2, 5, 6, 12, 19, 25, 31, 46), while

simultaneously pretending that it lacks market power. In fact, ABMS has so much market power that some state legislatures have banned requiring purchase of its product, as explained in the Amended Complaint. (Am. Compl., Dkt. #49, ¶¶ 4, 60, 106) Yet ABMS ignores the significance of those bans as to the issue of market of power. The state law bans would not occur unless ABMS has market power to create the need for them. Of course, the state bans do not absolve ABMS of its legal accountability in federal court under the Sherman Act.

E. ABMS Has Engaged in Anticompetitive Conduct.

Plaintiff AAPS does not merely disagree with MOC, as ABMS argues. (ABMS Br. 31-32) AAPS objects to ABMS arranging for the requirement of physicians to purchase and comply with the widely criticized proprietary product of ABMS.

ABMS is simply incorrect in arguing that AAPS's sole recourse is to obtain more state legislation to prohibit the requirement of MOC, as Texas has done. (ABMS Br. 32) The Sherman Act prohibits the restraint of trade that makes such state legislation necessary. A valid cause of action exists to eradicate the underlying restraint of trade for which state legislation attempts to minimize the ensuing harm.

II. Plaintiff AAPS Has Alleged an Unlawful Tying Arrangement.

The tying of ABMS's MOC product to hospital medical staff privileges and health insurance networks is more sophisticated than a simple, textbook-style tying, as AAPS explained in its opening brief. (AAPS Br. 33-34) ABMS responded by arguing, in

effect, that only textbook-style tying arrangements are prohibited by the Sherman Act. ABMS is incorrect about the law.

Tying doctrine arose to prevent the very kind of restraint of trade which is at issue in this case. ABMS argues that "[t]here can be no tie as alleged by AAPS because ABMS has no control over medical staff privileges or insurance network coverage, and 'absolutely no economic interest in the sales' of hospitals and insurers." (ABMS Br. 35, quotations in original) To the contrary, ABMS revenue obviously increases the more that hospitals and insurers require its product. It is not necessary that ABMS have "control" over hospitals and insurers, but merely that ABMS arrange for them to agree to the tying arrangement that boosts ABMS revenue. Hospital medical staff privileges and insurance networks are distinct products from MOC, and tying the latter to the former is precisely the sort of tying which is contrary to the Sherman Act.

As the Second Circuit has explained:

> The [Supreme Court] majority in *Jefferson Parish* does not require any "economic interest" by the tying seller in the tied-product market.

Gonzalez v. St. Margaret's House Hous. Dev. Fund Corp., 880 F.2d 1514, 1517 (2d Cir. 1989) (referencing *Jefferson Parish Dist. No. 2 v. Hyde*, 466 U.S. 2 (1984)). "Control" by the tying seller is not required in the tied-product market in order to constitute an unlawful restraint of trade.

The cases on which ABMS relies are inapposite here. *See, e.g.*, *Kenney v. Am. Bd. of Internal Medicine*, No. 20-1007, 2021 U.S. App. LEXIS 5595 (3d Cir. Feb. 25, 2021) (cited

by ABMS Br. 3, 25, 26, 33) In the ***non-precedential*** *Kenney* decision, the procedural posture was a motion to dismiss such that no factual findings were made, and the alleged tie was between original certification and MOC by the American Board of Internal Medicine (ABIM). The Third Circuit (and the district court) found that those products were not sufficiently distinct from each other. *Id.* at *10-11. Here, the distinct products are hospital medical staff privileges and MOC, and insurance networks and MOC, which are separate from each other and thus tying doctrine fully applies.

Similarly, ABMS is not helped by the decision in *Reifert v. S. Cent. Wis. MLS Corp.*, 450 F.3d 312 (7th Cir. 2006). That decision affirmed a grant of summary judgment, where factual development provided the basis for denying a claim for tying. The tied product in that case was membership in a realtor association for which there was no competition, and thus no anti-competitive impact. *Id.* at 319. Here, in contrast, the impact on the market involving hospital medical staff privileges and insurance networks is pronounced. Patients are unable to be seen by their preferred physicians when they are in hospitals, and unable to obtain insurance reimbursement, due to the restraint of trade by ABMS. These issues should not be resolved on a motion to dismiss, as the district court erred in doing.

III. Plaintiff Has Adequately Alleged Antitrust Injury Caused by ABMS, and It Would Be Premature for This Court to Address This Issue.

The decision on appeal expressly did ***not*** reach the issue of antitrust injury. (A-14, Dkt. #96) Despite that, ABMS devotes a chunk of its brief to arguing the issue of

antitrust injury anyway. (ABMS Br. 35-39) At most that issue should be remanded to the district for it to resolve in the first instance, before addressing it here on appeal.

As to the substance of its argument, ABMS errs in denying antitrust injury. Again ABMS's arguments are precluded by the precedent of *Wilk v. American Med. Ass'n*, 895 F.2d at 364-65, which discusses and rejects a similar objection based on antitrust injury. The exclusion from the market of chiropractors due to actions taken by the AMA did not necessarily cause patients to go without access to any physician, or compel patients to see unqualified physicians, which is a flawed test that ABMS urges upon this Court in its brief. (ABMS Br. 37) Medical care is highly personalized, and the issue is not whether a patient has access to a qualified physician, but whether the patient has access to his or her preferred physician. The Amended Complaint gives a specific example of a physician (J.E.) whose patients cannot have access to at a local hospital due to the restraint of trade caused by ABMS with MOC. (Am. Compl., Dkt. #49, ¶¶ 32-52) The pleading explains that this suppression in output of medical services is pervasive and affects many physicians. (*Id.* ¶¶ 66, 89) As in *Wilk*, this is an actionable antitrust injury, and dismissal would be improper based on this issue.

Several of ABMS's arguments about antitrust injury are illogical. ABMS argues that physician J.E. has not reduced his output because he still sees patients outside of the hospital where he is excluded for not having participated in MOC. (ABMS Br. 37) But his patients who are hospitalized cannot be seen by him while in the hospital. This

is plainly a reduction in relevant output, and potentially a fatal one. ABMS increases its revenues through its MOC program by impeding continuity of care, and that constitutes a restraint of trade in violation of the Sherman Act.

ABMS is simply wrong in arguing that "[n]either ABMS nor its MOC program has proximately caused any asserted harm to physicians." (ABMS Br. 38) AAPS alleges the immense harm caused by ABMS and its unwanted MOC mandates on physicians, including:

> 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.

(Am. Compl., Dkt. #49, ¶ 56) Yet ABMS implausibly argues, without any basis in the record, that "consumer choice" is somehow the real cause of the exclusion of physicians from hospital and insurance networks. (ABMS Br. 38, quoting the Ninth Circuit decision in *McDaniel v. Appraisal Inst.*, 117 F.3d 421, 423 (9th Cir. 1997)). *McDaniel* involved an appeal from a grant of summary judgment, and based its decision on the lack of evidence at that stage in support of the claim. The Ninth Circuit expressly distinguished its ruling from when a case is at the motion to dismiss stage, as this case is. *Id.* ("That was a 12(b)(6) case, this is a summary judgment case, so in the case at bar, unlike [the other one], it was incumbent on plaintiff to present evidence.").

ABMS further argues that the massive amount of lost time due to MOC compliance – often in excess of 100 hours per year (Am. Compl., Dkt. #49, ¶ 46) – may

not "have been passed onto patients in the form of increased prices or reduced output." (ABMS Br. 37) But the Amended Complaint alleges precisely that the lost time is passed onto patients in reduced output:

> For the average physician in clinical practice, that ***time burden takes the physician's availability away from more than 700 patient-visits per year***.

(Am. Compl., Dkt. #49, ¶ 47, emphasis added) That restraint by ABMS directly reduces output to patients (consumers), and thereby constitutes antitrust injury.

ABMS confusingly cites an earlier decision concerning the original Complaint, before the amended pleading was filed. (ABMS Br. 36 n.3) The Amended Complaint superseded the initial one, and the district court decision at issue on appeal now expressly declined to rule on antitrust injury. ABMS's argument on this point is thus both premature and incorrect. ABMS's restraint of trade in its MOC program blocks access by many patients to many preferred physicians. To the extent the reduction needs to be quantified, there needs to be discovery in this case to develop those facts. *See, e.g.*, *Brader v. Allegheny Gen. Hosp.*, 64 F.3d 869, 876 (3d Cir. 1995) ("[T]he existence of an 'antitrust injury' is not typically resolved through motions to dismiss.").

IV. Plaintiff AAPS Has Standing.

ABMS does not dispute that AAPS has standing to seek injunctive relief, which is its primary goal. ABMS does argue that AAPS lacks standing to obtain damages on behalf of its members, but this was not an issue reached by the lower court and should not be resolved in the first instance by this Court on appeal. (ABMS Br. 39-40) It is

noteworthy that the relief ordered in the landmark case of *Wilk v. American Med. Ass'n* was injunctive, and similar injunctive relief would be fully justified here. *Wilk*, 895 F.2d at 357 (district court "ordered injunctive relief" and the Seventh Circuit affirmed).

V. Plaintiff AAPS Has Adequately Alleged a Violation of the Illinois Uniform Deceptive Trade Practices Act.

A Seventh Circuit decision on which ABMS relies suggested that misconduct by a specialty board could be addressed through "a theory of deception." *Sanjuan*, 40 F.3d at 251 (Easterbrook, J.). Indeed, the Amended Complaint sets forth a valid cause of action under the Illinois Uniform Deceptive Trade Practices Act (UDTPA), for how ABMS disparages physicians in order to induce them to purchase its otherwise unwanted product. Specifically, ABMS disparages reputations by stating that individual physicians are "Not Meeting MOC Requirements." It does so while characterizing itself as a "Board", which typically implies a governmental or official affiliation. AAPS has stated a valid cause of action, and factual development of a record is necessary before resolving this claim.

ABMS implausibly defends its disparagement of the non-customer physicians as "Not Meeting MOC Requirements," by asserting that "[a]t most, it communicates that ABMS does not 'endorse' a given physician." (ABMS 42) But non-endorsement can be easily conveyed without disparagement, as is often done in the political realm by endorsing one candidate but not his opponent. The phrase "Not Meeting MOC Requirements" plainly implies some sort of regulatory violation, or a failure

tantamount to a violation of some kind of legal requirement. The inference of that negative connotation should have been drawn in favor of the cause of action on the motion to dismiss below. It was a reversible error to infer otherwise.

As alleged and argued in AAPS's opening brief and unrebutted in ABMS's reply, it is improper for companies to try to shame people into buying their products by publicly calling them out for not doing so. (AAPS Br. 14) "Not Meeting Amazon Prime Requirements" could be said by Amazon about those who decline to purchase the Amazon Prime service. That might boost sales of the product as some try to get off the list of negative publicity. But it would be a deceptive trade practice actionable under Illinois law.

Likewise, it is deceptive for ABMS to connote that it is some kind of official "Board" when it is not. Agents of Federal Express cannot properly describe themselves to the public as "federal agents" demanding compliance, even though "federal" is in the name of "Federal Express." Certain terms have connotations of governmental authority, and "Board" is one of them, particularly in the medical context. It is an issue of fact as to whether ABMS has been wrongly exploiting that official connotation in order to boost sales of its commercial product.

ABMS argues that its statements are "simply true" (ABMS Br. 44) but the connotations are simply ***not*** true, and thus a cause of action exists. ABMS also argues that the allegations "do not plausibly allege communications about an identifiable good

or service," but they do refer to physicians' services. The pejorative phrase "Not Meeting MOC Requirements" refers to the practices of physicians, which are the services on which their livelihood depends. Indeed, a more negative general statement about physicians' services is difficult to imagine, and a valid cause of action exists against this disparagement by ABMS.

ABMS misplaces reliance on two UDTPA cases. *See Labor Ready, Inc. v. Williams Staffing, LLC*, 149 F. Supp. 2d 398 (N.D. Ill. 2001); *Associated Underwriters of Am. Agency, Inc. v. McCarthy*, 826 N.E. 2d 1160, 1169 (Ill. App. Ct. 2005). In *Labor Ready*, the district court denied the motion to dismiss with respect to the UDTPA claim. *See Labor Ready*, 149 F. Supp. 2d at 413. There, as here, injunctive relief was sought for the misleading disparagement of services, which is a valid cause of action under the UDTPA, both in *Labor Ready* and here. In *Associated Underwriters*, the court affirmed a grant of summary judgment against a UDTPA claim where, in fact, there was not any evidence of disparagement. In contrast, in the district court below factual development to reach the summary judgment stage was not allowed on an allegation that quotes actual disparagement. The grant of dismissal below on this UDTPA claim should be reversed.

VI. The District Court Abused Its Discretion By Dismissing Plaintiff's Complaint With Prejudice.

The dismissal below was with prejudice, thereby foreclosing a future challenge to restraint of trade by ABMS even if more evidence is revealed about how it arranges for others to require its product. As argued in AAPS's opening brief, the district court

erroneously shut the door on future antitrust challenges as evidence is uncovered about the coercion. (AAPS Br. 39-40) The dismissal should not preclude a future challenge when more evidence of an agreement by ABMS is uncovered.[5]

After *Twombly*, dismissals with prejudice should be limited to where "[i]t is evident from the proceedings in the district courts and the arguments in plaintiffs' appellate briefs that the defects in these cases cannot be corrected, so that further amendment would be futile." *Sharif Pharmacy, Inc. v. Prime Therapeutics, LLC*, 950 F.3d 911, 919 (7th Cir. 2020). This case at bar is not about a fundamental misunderstanding of antitrust law which was dispositive in *Sharif*. Also, unlike here, in *Sharif* the dismissal was without prejudice on the supplemental state law claims. *Id.*

VII. ABMS's Request for a Show Cause Order is Inappropriate and Unjustified.

With the arrogance of a monopolist, ABMS improperly seeks sanctions merely for being challenged in court about its restraint of trade. But ABMS itself fails to comply with FED. R. APP. P. 38, which requires "a separately filed motion" from a party seeking sanctions on appeal, which ABMS did not do.

Instead, ABMS relies entirely on a decision involving extensive misconduct which is nowhere present here. *McCurry v. Kenco Logistics Servs., LLC*, 942 F.3d 783, 790-

[5] AAPS did not file a motion for leave to amend below because this appeal was taken directly after the dismissal below was entered with prejudice.

93 (7th Cir. 2019) (cited by ABMS Br. 45-46). In *McCurry*, the Court so acted because "the rules [we]re violated … [and] the violations are multiple and flagrant." *Id.* at 790.

Ironically, one of bases for the show cause order there was that the party relied on "factual assertions that were excluded from consideration below." *Id.* at 791. Here, the brief by ABMS contains many factual assertions found nowhere in the record (the Amended Complaint), and ABMS mischaracterizes what is in the record.[6]

CONCLUSION

For the foregoing reasons and those set forth in the opening brief, the decision below should be entirely reversed.

Dated: April 29, 2021

Respectfully submitted,

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[6] For example, ABMS misleadingly asserts that "[t]he Amended Complaint alleges only that ABMS has encouraged hospitals and insurers to adopt the voluntary MOC program. (*See*, *e.g.*, Dkt. 49 at ¶ 19.)" Yet the very paragraph 19 which ABMS cites expressly alleges that "Defendant ABMS … ***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.*, emphasis added)

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 6,495 words, excluding the parts of the document exempted by Fed. R. App. P. 32(f).

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Dated: April 29, 2021

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CERTIFICATE OF SERVICE

I hereby certify that on April 29, 2021, the Reply 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
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