No. 24-1994

IN THE UNITED STATES COURT OF APPEALS
FOR THE SEVENTH CIRCUIT

Emily Elizabeth Lazarou, and Aafaque Akhter, individually and on behalf of all others similarly situated,

Plaintiffs-Appellants,

v.

American Board of Psychiatry and Neurology,

Defendant-Appellee.

Appeal from the United States District Court
for the Northern District of Illinois, Eastern Division,
Case No. 1:19-cv-01614
The Honorable Judge Jeremy C. Daniel

REPLY BRIEF OF PLAINTIFFS-APPELLANTS

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Oral Argument Requested

TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Cases **Page**

Statutes

Other

INTRODUCTION

ABPN does not dispute in its Brief and thereby concedes that as Plaintiffs contend, the District Court's holdings: "ignore well-pleaded factual allegations, demand a level of evidentiary detail not required by pleading jurisprudence, fail to consider all allegations and inferences in the light most favorable to Plaintiffs, and [are] based on inappropriate adverse inferences ... ." AOB 15-16.[1] Instead, ABPN argues that *stare decisis* and other "multiple alternative grounds" not relied upon by the District Court warrant dismissal of the Second Amended Complaint. AEB 6-7. Because as described below the doctrine of *stare decisis* is inapplicable and the alternative grounds posited by ABPN are similarly without merit, Appellants respectfully request that the dismissal be reversed.

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[1] References to "AOB ___" are to pages of Plaintiffs' Opening Brief at Appellate Docket 12. References to "AEB ____" are to pages of ABPN's Brief at Appellate Docket 18. References to "A-___" are to the District Court opinion included in the Required Short Appendix at A-2-21. References to "¶ ___" are to paragraphs of the Second Amended Class Action Complaint ("SAC"), included in the Separate Appendix of Plaintiffs-Appellants at SA-1-51. References to "Dkt. ___" are to the District Court docket.

PRIOR HISTORY AND THE "PARALLEL SISTER CASES"

ABPN cites *Siva* v. *Amer. Bd. of Radiology*, 38 F.4th 569 (7th Cir. 2022), and *Kenney v. Am. Bd. of Internal Medicine*, 847 F. App'x. 137 (3rd Cir. 2021) (designated "NOT PRECEDENTIAL"), as if they mandate affirmance. *See* AEB 5 (referring to "the parallel sister cases"), 9-10. The claims in *Kenney*, however, were dismissed after the district court, affirmed by the Third Circuit, wrongly analyzed separate products at the post-tie stage, that is, *after* the tie had already been imposed. *Kenney v. Am. Bd. of Internal Medicine* 412 F. Supp. 3d 530, 543-549 (E.D. Pa. 2019). The *Siva* district court, calling the *Kenney* district court opinion "persuasive," likewise used a post-tie analysis when it found certifications and MOC to be a single product. *Siva* v. *Amer. Bd. of Radiology*, 512 F. Supp. 3d 864, 870 (N.D. Ill. 2021).

On appeal from the *Siva* district court ruling, however, this Court made clear, relying on *Viamedia, Inc. v. Comcast Corp.*, 951 F.3d 429 (7th Cir. 2020), that when considering separate products, only the pre-tie stage matters:

> "Courts performing this inquiry [the demand for the two items] must assess market demand 'at the pre-contract rather than post-contract stage'—before the alleged tying arrangement went into effect. *Viamedia, Inc. v.*

> *Comcast Corp.*, 951 F.3d 429, 469 (7th Cir. 2020) (citing Areeda & Hovenkamp¶ 1802d6). Doing otherwise by looking at market demand in the post-tie world runs the risk of 'immuniz[ing] the worst-case scenario of a successful tie by which a monopolist successfully leverages a monopoly in the tying product into a monopoly in the tied product.' Areeda & Hovenkamp ¶ 1745d1."

Siva, 38 F.4th at 575.[2] In short, *Siva* found that *Kenney* and the *Siva* district court had mistakenly analyzed separate products after the alleged tie had already been imposed.

Accordingly, *Kenney* is simply inapposite as it is premised on a separate products analysis totally at odds with *Viamedia*; it also never considered the issue at hand in this appeal: whether MOC is plausibly alleged in the SAC to be a substitute for other CME products. *Siva*, on the other hand, contrary to ABPN's insistence, requires reversal not affirmance because as shown in Plaintiffs' Opening Brief, the allegations this Court found missing in *Siva* showing that MOC is a

[2] *Viamedia* was decided after the district court and Third Circuit opinions in *Kenney* and the *Siva* district court opinion.

substitute for other CME products have been fully addressed in the SAC. *See* AOB 19-46.[3]

ABPN is also wrong when it claims the only "ostensible" difference between the First Amended Complaint ("FAC") and the SAC is the use of "CME" rather than "CPD." *See* AEB 11. The terms CME, CPD (continuing professional development), and CME/CPD are interchangeable and have been used as such in the medical industry and throughout this litigation to refer to medical "lifelong learning" educational products.[4] As *Siva* acknowledged: "[t]he terms CME and

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[3] Because the complaints dismissed by the district courts in "the "parallel sister cases" and the First Amended Complaint here (Dkt. 63; Appellee Supplemental Appendix) were filed before *Siva,* the SAC is the first time Plaintiffs' additional factual allegations made in response to *Siva* that MOC is a substitute for other accredited CME products have been considered by any court.

[4] *E.g.*, Initial Complaint below, Dkt. 1, ¶¶ 42, 43 ("the stated MOC goals [are] continuous and ongoing learning and improvement" and "CME is also already designed to identify knowledge gaps, develop educational programs to address those gaps, and utilize adult learning principles to give physicians the skills, competencies, and intellectual fulfilment required for their practice. These are precisely the goals of ABPN MOC."); FAC, ¶¶ 8, 113 ("CPD products like MOC promote individual, self-directed lifelong learning and the development of both medical and non-medical competencies after residency … " and "The terms CME and CPD are sometimes used interchangeably or in tandem, for example as 'CPD/CME.'"); SAC ¶¶ 9, 92, ("Over time, the AMA, ABPN, and others have sometimes referred to CME products as continuing

CPD are sometimes used interchangeably or in tandem, for example as "CPD/CME.'" *Siva*, 38 F.4th at 579.

Siva ultimately settled on the term CME, emphasizing that the relevant product market "seems primarily to be one for educational content accredited to satisfy state CME requirements." *Id*. Using "CME" in the SAC simply acknowledges *Siva's* analysis that the relevant product market is premised on the primary importance of the use of CME products for State licensure.

ARGUMENT

I. Standard On Rule 12(b)(6) Motion To Dismiss

The Seventh Circuit applies the same dismissal standards in antitrust cases as in any other case. "At this stage, we accept all well-pleaded facts as true and draw all reasonable inferences in Vasquez's favor." *Vasquez v. Indiana University Health, Inc.*, 40 F.4th 582, 583 (7th Cir. 2022) (reversing 12(b)(6) dismissal of antitrust case); *Viamedia,* 951 F.3d at 454 (same; "We review *de novo* a grant of a motion to dismiss,

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professional development ([CPD]) products, using the terms interchangeably" and "MOC promotes 'commitment to lifelong learning through continuing medical education and other educational programs, and some assessment of practice-based performance.'").

"constru[ing] the complaint in the light most favorable to the plaintiff, accepting as true all well-pleaded facts alleged, and drawing all possible inferences in [its] favor.")

Thus, while this Court has noted it is "particularly important in the antitrust context" to "ensur[e] compliance with [the *Twombly*] standard," contrary to ABPN's apparent belief (*see* AEB 8), *Siva* does not stand for imposing heightened pleading requirements in antitrust cases. 38 F.4th at 575. *See also Vasquez*, 40 F.4th 582 at 586-587 (quoting from *Twombly*: "detailed factual allegations" or "probability of the plaintiff's recovery" not required, only "a reasonable expectation that discovery will reveal evidence" of illegal acts.). *Twombly* alleged multiple agreements and conspiracies among multiple actors, and was dismissed because no facts were alleged from which it was plausible to conclude the existence of the asserted agreements and conspiracies. *Bell Atl. Corp. v. Twombly*, 550 U.S. 544 (2007). Multiple agreements, conspiracies, and actors are not at issue here.

As to potential discovery expense, there is nothing in this record indicating that the Supreme Court's concerns in *Twombly* are at play here:

> "That potential expense is obvious enough in the present case: plaintiffs represent a putative class of at least 90 percent of all subscribers to local telephone or high-speed Internet service in the continental United States, in an action against America's largest telecommunications firms (with many thousands of employees generating reams and gigabytes of business records) for unspecified (if any) instances of antitrust violations that allegedly occurred over a period of seven years."

550 U.S. at 559.

The putative class here is much smaller, according to the ABPN 2023 Annual Report there are currently about 61,000 diplomates (less the 22 percent that have been grandfathered) compared to the tens or perhaps hundreds of millions of class members in *Twombly*; ABPN is believed to have a vastly smaller number of employees than "many thousands," most of whom are not expected to have relevant information; "reams and gigabytes of business records" are not involved; ABPN is the sole defendant, unlike *Twombly* where defendants included "America's largest telecommunications firms"; and the SAC concerns only one discrete aspect of ABPN's operations (MOC) and a single antitrust claim (tying) rather than a number of "unspecified" conspiracy claims. This is not to say discovery will be insignificant, but there is nothing to suggest it will be more extensive than many other commercial litigation matters.

And ABPN certainly has not come forward with any data or evidence to the contrary.

II. ABPN's *Stare Decisis* Argument Ignores The SAC's New Factual Allegations.

Stare decisis is inapplicable here and rests on ABPN's false premise that there are no new allegations in the SAC addressing this Court's holding in *Siva*. As set out in detail in Plaintiffs' Opening Brief, however, there are substantial additional factual allegations showing that MOC is a substitute for other CME products. *See* AOB 19-46. Thus, the very real as opposed to "ostensible" difference between the *Siva* complaint and the SAC here, studiously ignored by ABPN (*see*, *e.g.*, AEB 10-11), is that as instructed by *Siva*, the SAC alleges in detail that (1) MOC has educational content, (2) doctors earn CME credit for MOC, and (3) MOC is not redundant of other CME requirements. *See Siva,* 38 F.4th at 579-80. Stated another way, because of these new allegations, reversal here would be consistent with *Siva*, and would not in any sense be "overruling" it. *See* AB 11 ("*stare decisis* bars overruling an appellate court decision without a compelling reason").

Importantly, *Siva* was based on a pleading deficiency and did not find as a matter of law that MOC is not a CME product. Rather, it

specifically noted that "at least on the allegations in Siva's present complaint," separate products had not been pleaded. 38 F.4th at 580. Thus, the doctrine of s*tare decisis* has no application here. *See*, *e.g.*, *Deckers Corp. v. United States*, 752 F.3d 949, 956 (Fed. Cir. 2014) ("*Stare decisis*, therefore, is limited to only the legal determinations made in a prior precedential opinion and does not apply to either issues of fact … or issues of law that were not part of a holding in a prior decision); *U.S. v. Nolan*, 136 F.3d 265, 269 (2d. Cir. 1998) (*stare decisis* "is applicable only where the facts in the two actions are the same"); *Beacon Oil Co. v. O'Leary*, 71 F.3d 391, 395 (Fed. Cir. 1995) ("*Stare decisis* applies only to legal issues that were actually decided in a prior action."); *Gately v. Comm. of Mass.*, 2 F.3d 1221, 1226 (1st Cir. 1993) ("As *stare decisis* is concerned with rules of law, however, a decision dependent upon its underlying facts is not necessarily controlling precedent as to a subsequent analysis of the same question on different facts and a different record.").

None of the cases ABPN cites supports the doctrine's application in circumstances such as those here where an amended complaint contains new factual allegations addressing specific concerns raised in a prior

decision. Instead, the cases ABPN relies on either applied *stare decisis* to a pure legal question or did not apply it at all. *See Michigan v. Bay Mills Indian Community*, 572 U.S. 782 (2014) (pure legal issue of whether tribal immunity applies to commercial activity outside Indian territory); *Payne v. Tennessee*, 501 U.S. 808 (1991) (declining to apply *stare decisis* to question of criminal procedure); *Gilbank v. Wood Cnty. Dep't of Hum. Servs.*, 11 F.4th 754 (7th Cir. 2024) (*stare decisis* applied to pure legal issue of whether *Rooker-Feldman* doctrine applies to a federal claim for damages based on an injury inflicted by a state-court judgment); *Wilson v. Cook County*, 937 F.3d 1028 (7th Cir. 2019) (*stare decisis* applied to pure legal issue of whether assault weapons bans violate Second Amendment, rejecting argument that prior Circuit decision on the issue depended on facts unique to that case); *Midlock v. Apple Vacations West, Inc.*, 406 F.3d 453 (7th Cir. 2005) (*stare decisis* inapplicable to district court decisions); *Bethesda Lutheran Homes & Servs. v. Born*, 238 F.3d 853 (7th Cir. 2001) (*stare decisis* does not apply where, such as here, there is "important new information" alleged after the prior decision).

Finally, it is of no moment that the Third Circuit in its non-precedential *Kenney* opinion affirmed dismissal of the complaint in that

case. *See* AB 9-10. Among other things, the complaint in *Kenney* did not include the new *Siva*-directed allegations added to the SAC here, and, as discussed above, the Third Circuit opinion was based on a post-tie analysis contrary to this Court's holding in *Viamedia*. Similarly, *Ass'n of Am. Physicians & Surgeons, Inc. v. Am. Bd. of Med. Specialties*, 15 F.4th 831, 835 (7th Cir. 2021), involved a conspiracy to restrain trade, not a tying claim, and concerned none of the issues addressed in *Siva* or relevant to this appeal. *See* AEB 10.

III. ABPN's "False Equivalence" Argument Disputes, Contrary To The SAC And *Siva*, That The CME Market Is The Relevant Product Market, Misstates The Facts, And Raises Issues Of Fact Not Properly Considered On A Motion To Dismiss.

ABPN asserts that Plaintiffs' tying claims are based on a so-called "false equivalence" and that "the proper logical comparison" is not between MOC and other CME products. *See* AEB 12, 13. It argues instead that the relevant product market is "physician licensure" and that because MOC and licensure are not "interchangeable" the tying claims fail. *Id*. ABPN offers no explanation why this alternative product market makes economic or legal sense.

Siva found CME products and certifications are separate products, and was clear that the *Siva* plaintiff fell short because he had not pleaded "facts making it plausible that MOC is a substitute for other [CME] products" and that without such allegations he could not identify a distinct product market separate from certifications. 38 F.4th at 578 (citation omitted), 581. The SAC here, on the other hand, alleges facts making it more than plausible that MOC is a substitute for other CME products, showing that like other CME products MOC is distinct from certifications. *See* AOB 19-46. Nowhere in *Siva* is there even a hint that the relevant product market should be physician licensure, and ABPN unsurprisingly does not include a single citation to *Siva* (or any other precedent) in support of its "false equivalence" argument.

ABPN's accusation that Plaintiffs employ some sort of untoward "deconstructionist logic" by separating MOC's Activity Requirements and Assessment products misstates the facts and is classic misdirection. *See* AEB 12. ABPN, not Plaintiffs, has separated MOC into two components, the Activity Requirements and ABPN's own Assessment products, a separation validated by the American Medical Association

by its award of direct CME credit for ABPN's Assessment products. *See* AOB 6-7, 10.

Nor do Plaintiffs "equate" the credits earned from third-party CME products mandated by ABPN's Activity Requirements to other third-party CME products, or make "a false comparison" of third-party CME products in one context to "the exact same third-party" CME products required by ABPN's Activity Requirements. *See* AEB 12. Plaintiffs do not allege that the CME credits earned from meeting MOC's Activity Requirements result in any additional CME credit. Only ABPN's own required Assessment products earn direct CME credit. Nor do Plaintiffs "equate" or double count CME credits earned from ABPN's Activity Requirements. This is simply a rephrasing of the "MOC is redundant" concern discussed in *Siva*. 38 F.4th at 579-580. As explained in Plaintiffs' Opening Brief, however, MOC does not impose a redundant obligation. *See* AOB 42-46. That explanation is not disputed in ABPN's Brief. [5]

[5] ABPN's "false equivalence" argument ignores the direct credit toward licensure earned by doctors from its Assessment products, which *Siva* instructs is the proper comparison since demand for CME products is "driven largely by state licensing requirements." *See Siva*, F.4th at 579.

Finally, ABPN's one-paragraph argument that in order to be a substitute for CME products MOC must be "required for state licensure" is frivolous. *See* AEB 13. Plaintiffs are not aware of any individual CME product required by any state for licensure. Nor does ABPN identify any such product. But even if there were one, there are countless other CME products that, like MOC, are not required. Thus, MOC is no different from other CME products in this regard.[6]

If ABPN wishes to deny that the relevant product market alleged by Plaintiffs and analyzed by this Court in *Siva* is the CME market, and instead propose a physician licensure market as an alternative it remains free to do so in its Answer. The relevant product market and whether a products falls within that market, however, are highly fact-intensive inquiries not properly considered on a motion to dismiss. *See*

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[6] ABPN's reliance on the District Court fails for the reasons already discussed in Plaintiffs' Opening Brief. *See* AEB 13, quoting A-15. First, MOC can be a substitute for other CME products without being required. *See* AOB 35. And second, the District Court's finding that MOC is "primarily" an obligation to buy CME products from others is an improper and inaccurate factual finding. The MOC Assessment component can only be satisfied by ABPN's own Assessment products, is required for doctors to keep their certifications from being revoked, and is no less a primary "obligation" of MOC than the Activity Requirements component. *See* AOB 22-23.

AOB 18-19. *See also Vasquez*, 40 F.4th at 586 (Rule 12(b)(6) motion brought against claimed antitrust violations "not the time to evaluate the merits of [plaintiff's] allegations, and that in any event is a task that requires expert testimony.").

IV. Plaintiffs More Than Satisfy *Siva*'s Requirements For Plausibly Alleging That MOC Is A Substitute For Other CME Products.

In *Siva* this Court held that because the plaintiff there had not alleged MOC contains "educational content" or that doctors "could earn CME credits" from MOC for state licensure, and since MOC as alleged in that case "simply impose[d] a redundant obligation" to buy other CME products, it had not been plausibly alleged that MOC was a CME product. 38 F. 4th at 579. The SAC here addresses these issues with plausible and well-pleaded allegations not included in the *Siva* complaint. *See* AOB 19-46. In arguing that MOC is not a substitute for CMEs, ABPN largely ignores these new allegations and does not engage with most of the discussion in Plaintiffs' Opening Brief. The few arguments ABPN makes are easily debunked.

First, ABPN falsely states that Plaintiffs allege "MOC is worthless and would never be purchased regardless of the price of CMEs." *See*

AEB 14. The words "worthless" and "useless" are nowhere to be found in the SAC and the allegations ABPN points to say no such thing. In particular, the cited SAC allegations discuss how pre-MOC voluntary CME products sold by ABMS member boards (including ABPN) were discontinued due to a lack of interest (¶¶ 88-90); those products were a precursor to MOC (¶¶ 90-91); MOC has the same purpose as other CME products (¶¶ 92-96); and ABPN forces doctors to buy MOC because the lack of interest in the voluntary CME product led ABPN to conclude MOC would not be successful in the CME marketplace unless doctors were forced to buy it (¶¶ 97-98). The remaining cited allegations summarize surveys showing there is no evidence, contrary to ABPN's purported rationale for MOC, that MOC actually improves patient care or physician competence. (¶¶ 134-144).

The inference from these allegations most favorable to Plaintiffs is not that MOC is "worthless" and "would never be purchased" (*see* AEB 14), but that MOC is an inferior product, and except for being forced to buy MOC to keep their certifications, doctors would purchase other CME products. In fact, that is precisely what is alleged in the SAC. (*E.g.*, ¶¶ 117, 132, 174, 202, 244). These allegations do not excuse ABPN's tie

but are instead the paradigm of an illegal tying arrangement. *See*, *e.g.*, *Viamedia*, 951 F.3d at 468 (seller purchases the tied product "not because the party imposing the tying requirement has a better product or a lower price" but because the seller has "power or leverage" in the market for the tying product) (internal quotation omitted). As Plaintiffs allege, "But for their certifications being revoked, psychologists and neurologists would buy CME products other than MOC from different CME providers, including CME products that are less expensive and more meaningful and relevant to their practice." (¶ 117; *see also* ¶¶ 174, 202).

Next, ABPN falsely contends that the SAC contains "[o]nly a single, conclusory allegation" related to "cross-price elasticity." *See* AEB. 14. In *Siva*, this Court instructed that allegations of substitutability need only "permit an inference" of "cross-price elasticity between MOC and other [CME] offerings," and went on to explain "in plainer English, [that] the two products must be 'reasonabl[y] interchangeab[le]' in the minds of relevant consumers." 38 F.4th at 578 (citation omitted). The SAC allegations discussed at length in Plaintiffs' Opening Brief include many well-pleaded facts showing MOC and CME products are interchangeable in the minds of doctors (and other stakeholders in the CME market). *See,*

e.g., AOB 23-42. These allegations more than meet *Siva's* requirement of alleging "an inference" of cross-price elasticity.

Importantly, ABPN itself has prevented alleging anything more. That is because ABPN artificially restricts "relevant consumers" by refusing to sell MOC, and specifically its Assessment products, to any doctor other than those it already forces to buy MOC to keep their certifications. Thus, it is impossible for Plaintiffs at this time to allege anything more specifically regarding cross-price elasticity than they already have, that "Because doctors are price sensitive, but for ABPN's tie, the cross elasticity of MOC and other CME products would be high," and that "a price increase in MOC would lead to significant switching by doctors to other CME products but for ABPN's tie that would result in their certifications being revoked." ¶ 201.[7]

[7] That ABPN sells its Assessment products only to doctors who have purchased certifications is a function of ABPN's ability to force those doctors to buy MOC. Approximately 90 percent of all doctors are certified by ABMS member boards. (¶ 25). ABPN's decision not to sell MOC to the remaining 10 percent, for whatever reason, is irrelevant to Plaintiffs' tying claims. *See* AEB 16. Plaintiffs suspect, however, that ABPN does not offer MOC for sale to the remaining 10 percent because it knows MOC is an inferior product that cannot succeed in the CME marketplace on its own merits.

ABPN concedes there are many states that accept MOC, but contends substitutability is undermined because "almost all such states" only accept MOC once every 10 years. *See* AEB 14-15. As an initial matter, the Iowa regulations cited by ABPN do not contain the wording quoted. But even assuming they did, it does not refer to a ten-year restriction. It instead provides that credit for MOC can be taken "during the [licensure] cycle in which the certification or recertification is granted." *Id.* But that does not distinguish MOC from other CME products since credit is always taken for CME products during the licensure cycle in which it is earned. *See also* AOB 40, n. 13.

Second, ABPN's ten-year argument applies only to the direct credit earned from the ABPN Exam Pathway Assessment product, which operates on a ten-year cycle. ABPN forgets its Article Pathway Assessment product that operates on a three-year cycle (¶ 102), meaning that 60 credits can be earned every three years, providing 200 CME Category 1 credits over ten years (20 per year on average), not just 60 credits every ten years. *See* AOB 28-29 and n. 8.[8]

[8] The use of direct credit from ABPN's Assessment products is not limited by any state and can be applied by doctors toward state CME requirements nationwide. (¶¶ 82, 120, 177 (Dr. Akhter), 199(e)).

ABPN also ignores that separate and apart from the direct credit earned from ABPN's Assessment products, many states accept "participating in" or "being up to date" with MOC in full or partial satisfaction of other CME requirements. AOB Exhibit A (California, Illinois, Iowa, New Hampshire, North Carolina, Oregon, Rhode Island, Texas, Washington, West Virginia). ABPN says nothing about these states. Acceptance of MOC by one state extends to almost all states through the Interstate Compact *See* AOB 49-50. [9]

Finally, ABPN mischaracterizes several states as "prohibit[ing] the consideration of MOC for maintaining physician licensure." *See* AEB 15-16. To be clear, *no state* prohibits MOC consideration, and any suggestion to the contrary is highly misleading. Rather, some states are specifically

[9] In addition to referring to wording that cannot be found in the Iowa regulations, ABPN's analysis of Iowa's licensure requirements is muddled. *See* AEB 15. As noted in Exhibit A of Plaintiffs' Opening Brief, Iowa credits a doctor with "the equivalent" of 50 CME Category 1 credits for participating in MOC during the two year licensure cycle. Iowa Admin. Code R. 653-11.2(2); 653-11(4)(1). Because MOC is a continuous ABPN requirement (or else doctors lose their certifications), recertification, by definition, occurs in every licensure cycle; thus, so long as Iowa doctors participate in MOC they earn "the equivalent" of 50 CME credits every two years. There can hardly be a clearer example of MOC being "the equivalent" of other CME products than the wording of the Iowa regulations.

not allowed to "require" certification or participation in MOC for licensure. *See*, *e.g.* Missouri (Mo. Ann. Stat. § 334.285(3) ("The state shall not require any form of specialty medical board certification or any maintenance of certification to practice medicine within the state."). Such a provision in no way "prohibits" a state from recognizing direct credit from ABPN's Assessment products or accepting MOC in full or partial satisfaction of other CME requirements. [10]

Notably, of the 15 states ABPN contends "prohibit" consideration of MOC (*see* AEB 15, n. 2), ten expressly accept MOC. *See* AOB Ex. A (Kentucky, Maine, Michigan, Missouri, North Carolina, North Dakota, Oklahoma, South Carolina, Texas, and Washington accept MOC in full or partial satisfaction of other CME requirements). And all states, including the remaining five that ABPN cites, accept direct credit earned from ABPN's Assessment products toward licensure.

V. ABPN Has A Substantial Financial Interest In MOC.

ABPN has a substantial financial stake in MOC. ABPN requires doctors to pay a $175 annual MOC fee or forfeit their certifications.

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[10] Plaintiffs have not "ignore[d]" this issue (s*ee* AEB 15), having addressed it in their discussion of state acceptance of MOC (*see* AOB 34-42).

(¶ 99). According to its Forms 990, ABPN reported net assets of $12,610,227 before the launch of MOC. (¶ 145). In the twenty years or so since ABPN began forcing doctors to buy MOC, its net assets have risen 1,344 percent to $169,554,844, including more than $140,000,000 in holdings in cash, savings, and securities at year-end 2022. (*Id.*). Most of the $157,000,000 increase is attributable to MOC fees. (*Id.*). Also according to ABPN's Forms 990, MOC revenue increased exponentially from $761,650 in 2013 to $9,580,374 in 2022 (the only years ABPN has publicly disclosed MOC data), or approximately 1,257 percent. (¶ 146). Based on the latest publicly available data, MOC generates more than a third of ABPN program revenue. (¶ 147)

ABPN intimates that it has a financial stake only in its own Assessment products which is just one component of MOC, thus applying its own "deconstructionist logic." *See* AEB 12. In any event, the un-deconstructed MOC is accepted by many states in full or partial satisfaction of other CME requirements. *See* AOB 34-42. No matter how ABPN slices it, whether it places the focus on ABPN's own Assessment

products or on the un-deconstructed MOC, the $175 annual MOC fee gives ABPN a substantial financial interest in MOC.[11]

VI. ABPN's Revoking Of Certifications Of Doctors Who Do Not Buy MOC Meets The Well-Settled Definition Of "Forcing."

Plaintiffs allege ABPN forces doctors to buy MOC (the tied product) because if they do not, ABPN revokes their certifications (the tying product). (*See*, *e.g.*, ¶¶ 11, 12, 24, 58, 62, 91, 98, 117, 162, 202, 208). This conditioned sale—buy MOC or ABPN will take away your certifications—meets the well-settled standard for "forcing" necessary for a tying claim. ABPN's argument misunderstands Plaintiffs' "forcing" allegations and is contrary to established law.

An illegal tie exists when a seller imposes the "condition that the buyer purchase the tied goods from the seller" if they want the tying product. *Viamedia*, 951 F.3d at 473; *see also id.*, at 496 (Brennan, J., concurring in part, dissenting in part) (forcing exists where "the

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[11] ABPN, referring to the dismissal of the FAC, also complains the SAC does not allege that ABPN has a financial interest in an "approved products list." *See* AEB 17. But the SAC dropped the allegations about the "approved products list" that the District Court had earlier found insufficient. *See* Dkt. 87, p. 14. And as already discussed *supra* 12-14 and n. 6, and AOB 22-23, 35, 42-46, MOC consists of more than "a requirement" that doctors "purchase CME products from other providers." *See* AEB 17.

defendant improperly imposes *conditions* that explicitly or practically require buyers to take the second product if they want the first one") (emphasis in original; quoting 10 Areeda & Hovenkamp, ANTITRUST LAW ¶ 1752b, p. 291 (4th ed. 2018) ("Areeda")). The requisite "conditioning" exists "when the defendant has utilized customers' desire for its product A to constrain improperly their choice between its product B and that of its rivals." Areeda, ¶ 1752e at 295. *See also id.* ¶ 1752e at 298 ("[T]he language of 'coercion,' 'forcing,' and 'voluntariness,' should be understood as inviting a specific factual inquiry about whether the defendant has illegitimately constrained buyer choices.").

The "conditioning" sufficient to establish an illegal tie is "clearly present" when, as here, "the seller ... continues to supply the tying product only to those who purchase its tied product." Areeda, ¶ 1700i, at 13. Plaintiffs allege that ABPN by revoking (*i.e.*, refusing to "continu[e] to supply") the certifications of doctors who do not purchase MOC, has "utilized customers' desire for" certifications "to constrain improperly their choice between" purchasing MOC and buying different CME products from other CME providers. ABPN's forcing is found in the

express condition it imposes on doctors to buy MOC or forfeit their certification. This is all Plaintiffs need allege to sustain a tying claim.

Economic realities are also relevant in assessing whether the seller's conditioning "constrains" the buyer's choice. In *Viamedia*, this Court found the purported option of retail cable providers bringing the tied product in-house (ad rep services) was "not a viable option," and it "[could not] affirm summary judgment by overlooking [the] evidence about the realities of the parties' dealings and the economic realities of the market." *Viamedia*, 951 F.3d at 471 and n. 17. Here, the "economic realities of the market" are that hospitals, insurers, and employers require doctors to hold certifications to obtain hospital privileges, insurance, and employment. (¶¶ 52-53, 55-57, 65-70, 71-72).

ABPN confuses these economic realities with the allegations that ABPN conditions certifications on the purchase of MOC. *See*, *e.g.*, AEB 18 (incorrectly contending the SAC pleads "that the adverse consequences of not maintaining Board certification are imposed by third parties like hospitals and insurance companies"). The economic realities are not themselves the "forcing." Instead, they help explain why ABPN's express condition constrains doctors' choices. ABPN's confusion is

reflected by the inapposite cases it cites, standing only for the unremarkable proposition that providing information, without any means to constrain choices, is not an actionable restraint of trade under antitrust law. Those cases are inapposite because by revoking certifications unless doctors purchase MOC, ABPN constrains buyers' choices.

Schachar v. Am. Acad. Of Opth., Inc., 870 F.2d 397 (7th Cir. 1989), concerned a claim of conspiracy to restrain trade based on a statement in an Academy press release describing a procedure the plaintiffs performed as "experimental." There was no tying claim alleged, and there was no "restraint of trade" because, unlike here, the Academy did not employ an "enforcement device" against doctors who continued performing the procedure. *Id.* at 398-399 ("It did not expel or discipline or even scowl at members who performed [the procedure]"). Here, ABPN employs the "enforcement device" of revoking certifications of doctors who do not purchase MOC.

Lawline v. American Bar Ass'n, 956 F.2d 1378 (7th Cir. 1992), also did not involve a tying claim, but rather an alleged conspiracy "to monopolize the dissemination of legal advice" through the promulgation

of ethical rules against the practice of law by non-lawyers. *Id.* at 1382. The antitrust claims failed not for any reason relevant to this case, but because the pertinent defendants were immune under *Eastern R Pres. Conf. v. Noerr Motor Freight, Inc.*, 365 U.S. 127, 136 (1961), and its progeny. As with *Schachar*, there was no antitrust liability because there was no actionable enforcement device due to the courts and ARDC being immune state actors. *Lawline*, 956 F.2d at 1383. Similarly, *U.S. Board of Oral Implantology v. Am. Bd. Of Dental Specialties*, 390 F. Supp. 3d 892 (N.D. Ill. 2019), did not involve a tying claim, but a claim for conspiracy to restrain trade that failed because the allegations of conspiracy were not plausible. *Id.* at 902-05.

Courts have found certification to be an economic necessity when hospital privileges or insurance hang in the balance for doctors. *Busse v. Am. Bd. of Anest., Inc.*, No. 92 C 5613, 1992 U.S. Dist. LEXIS 18948, *8 (N.D. Ill. Dec. 11, 1992) (certification an economic necessity when necessary to access area hospitals); *Liberman v. Am. Ost. Ass'n*, No. 13-15225, 2014 U.S. Dist. LEXIS 153012, *16-17 (E.D. Mich. Oct. 29, 2014) (same for insurance coverage). None of the cases ABPN cites hold otherwise. *Marrese v. Am. Acad. of Orthopaedic Surgeons*, Nos. 91-1366

and 1508, 1992 U.S. App. LEXIS 25530 (7th Cir. Oct. 1, 1992) (unpublished), concerned a doctor denied admission to the defendant Academy, which did not sell certifications or MOC. No tie was alleged and "forcing" was not at issue. Notably, however, one reason no antitrust violation was found was that "Academy membership was not necessary to receive hospital privileges." *Id.* at *16. Here, by contrast, and as alleged by Plaintiffs, most hospitals do require certification to receive privileges. (*E. g.*, ¶¶ 53, 56-58, 64, 65, 72).

ABPN cites *Ass'n of Am. Physicians & Surgeons, Inc. v. AM. Bd. of Med. Specialties*, No. 14-cv-02705, 2020 U.S. Dist. LEXIS 173853, *2-3 (N.D. Ill. Sept. 22, 2020), for the irrelevant proposition that state medical boards do not require MOC for licensure. *See supra* 14 and n. 6; AOB 35 ("MOC can be a substitute [for other CME products] without being required."). That court also did not address whether board certification is an economic necessity given its being required by hospitals, insurers, and employers. Finally, *Kaneria v. Am. Bd. of Psychiatry & Neurology*, 832 F. Supp. 1226 (N.D. Ill. 1993), did not involve tying or other antitrust claims but alleged breach of contract and fiduciary duty based on repeated decisions made ten times over thirteen years to deny Kaneria

certification. In the absence of sufficient allegations that certifications were an economic necessity, including the failure to allege that certification was a requisite to hospital privileges, the court dismissed the claims. 832 F. Supp. at 1229-1230. Again, Plaintiffs allege here that hospitals, insurers, and employers require certifications to obtain hospital privileges, insurance, and employment. (¶¶ 52-53, 55-57, 65-70, 71-72).

As *Viamedia* and Areeda make clear, ABPN's conditioned sale itself constitutes an illegal tie. Thus, even assuming "economic realities of the market" alone are insufficient to support a tying claim, ABPN "forces" doctors to buy MOC through its enforcement device of revoking certifications if they do not. At most, whether the condition ABPN has imposed constrains doctors' choices is a fact question that cannot be resolved without a full evidentiary record. *See Viamedia*, 951 F.3d 470-474 ("a seller is not immunized from a tying claim if there is a factual dispute as to whether the buyer wished to purchase" the tied product "from the defendant with market power" in the tying product).[12]

[12] While the District Court found the "forcing" allegations in the FAC lacking, it did so based on the allegation that doctors "may purchase ABPN's certification product without buying MOC … ." Dkt. 87, p. 20

VII. ABPN Is A Competitor In The CME Marketplace.

ABPN's "not a competitor" contention is nothing more than a reprise of its doomed "not a substitute" argument. *See supra* 15-21. As a substitute for other CME products, it is axiomatic that MOC competes in the CME market. *Siva*, 38 F.4th at 578-79 (that a product is a substitute for other products in the market establishes it is a "true competitor" in that market). And again, the SAC nowhere says that "MOC is effectively useless"; instead, doctors do not "value" MOC because, as discussed *supra* 15-17, it is an inferior product. S*ee* AEB 19.

ABPN misleadingly quotes from SAC ¶ 142, asserting Plaintiffs and other doctors find "no significant value" in MOC. *Id*. But the accurate quote is that 75 percent of doctors surveyed "agreed there was no significant value in MOC, *beyond what is already achieved from continuing medical education*." (¶ 142 (emphasis added)). Far from showing MOC is not a competitor in the CME marketplace, ¶ 142 confirms that doctors "view MOC and other CME products

(citing to FAC ¶ 348). That allegation, however, is not in the SAC and ABPN now automatically enrolls doctors in MOC (*i.e.*, forces them to buy MOC) when they purchase certifications. (¶¶ 159, 174; *see also* AEB 8-9).

interchangeably, recognizing they serve the same purpose and are commercial substitutes." (¶¶ 193, 199(a)).

The SAC alleges that MOC poses a clear threat to competition in the CME marketplace. Doctors buy fewer CME products from other CME providers as a result of the illegal tie, they use MOC as a "substitute" for other CME products, other CME vendors are at a competitive disadvantage as a result of ABPN's tie, and MOC "threatens a substantial foreclosure of competition in the [CME] market." (*E.g.*, ¶¶ 105, 117, 118 , 174, 177, 192-202, 206-208, 217). The SAC further alleges that "since the advent of MOC … the number of accredited providers of continuing medical education has declined almost 40% from 2,322 to 1,414." (¶ 217). The New England Journal of Medicine, refers to MOC as a "viable way" to "pick up bonus [CME] points" for licensure. (¶ 118). These and the other SAC allegations already discussed plausibly allege that MOC is a competitor in the CME marketplace.

VIII. If This Court Affirms, Plaintiffs Should Be Given Leave To Amend For The Limited Reason Requested.

ABPN does not dispute that the District Court when considering doctors' use of MOC to meet state licensure requirements, failed to consider all such allegations and inferences in the light most favorable to

Plaintiffs and also made inappropriate adverse inferences. *See* AOB 23-46. Nor does ABPN dispute that the District Court could have taken judicial notice of the publicly available state licensure statutes and regulations, or that this Court may also do so as part of its *de novo* review. *See* AOB 40-42.

If the Court nonetheless decides specific evidentiary details about individual state CME requirements should have been included in the SAC, Plaintiffs respectfully request that they be given leave to amend for this limited reason. See *supra* n.3.

CONCLUSION

Plaintiffs-Appellants ask this Court to reverse the District Court's dismissal of the Second Amended Class Action Complaint. Alternatively, Plaintiffs-Appellants respectfully request they be given leave to amend for the limited purpose requested.

Respectfully submitted,

Emily Elizabeth Lazarou, and Aafaque Akhter, individually and on behalf of all others similarly situated

Dated: October 21, 2024 By: /s/ C. Philip Curley
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CERTIFICATE OF COMPLIANCE WITH F.R.A.P. 32(a)(7)(B)

C. Philip Curley, counsel for Plaintiffs-Appellants, certifies that this brief complies with the type volume limitations of Federal Rule of Appellate Procedure 32(a)(7)(B). This brief was prepared in Century Schoolbook proportional font in Microsoft Word for Microsoft 365 MSO (Version 2408 Build 17928.20114) software and excluding the parts of the document exempted by Fed. R. App. P. 32(f) has 6,834 words, including footnotes, according to the Microsoft Word count.

Dated: October 21, 2024

/s/ C. Philip Curley
C. Philip Curley

CERTIFICATE OF SERVICE

C. Philip Curley, counsel for Plaintiffs-Appellants, certifies that on October 21, 2024, he caused to be electronically filed with the Clerk of the United States Court of Appeals for the Seventh Circuit **REPLY BRIEF OF PLAINTIFFS-APPELLANTS**, using the Court's CM/ECF system, which shall send notification of this filing to all counsel of record.

/s/ C. Philip Curley
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