No. 20-1007

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHLEEN MURRAY-LEISURE,

Plaintiffs-Appellants,

v.

AMERICAN BOARD OF INTERNAL MEDICINE,

Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Pennsylvania
Case No. 2:18-cv-5260-WB
The Honorable Judge Wendy Beetlestone

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STATEMENT OF JURISDICTION

(A) The district court had original jurisdiction over the subject matter of the case pursuant to 28 U.S.C. §§ 1331 and 1337 because it arises under the statutes and laws of the United States, specifically pursuant to the Clayton Act, 15 U.S.C. §§ 15 and 26, for violations of the Sections 1 and 2 of the Sherman Act (15 U.S.C. §§ 1 and 2), as well as under the federal Racketeering Influenced and Corrupt Organizations Act (RICO) (18 U.S.C. § 1961, *et seq*.). The district court had supplemental jurisdiction over the state law unjust enrichment claim pursuant to 28 U.S.C. § 1367.

(B) This Court has appellate jurisdiction pursuant to 28 U.S.C. § 1291, in that this is an appeal from a final decision of the district court disposing of all claims of all parties.

(C) The appeal in this matter was filed with the district court on December 30, 2019, and is timely because it was filed within 30 days after the district court's entry of its Stipulation and Final Judgment and Order on December 6, 2019.

ISSUES PRESENTED

(1) Whether the district court erred in concluding that Plaintiffs did not state claims for illegal tying under Section 1 of the Sherman Act when Plaintiffs sufficiently alleged Defendant American Board of Internal Medicine ("ABIM") illegally ties two separate products. A-33.

(2) Whether the district court erred in concluding that Plaintiffs did not state claims for monopolization under Section 2 of the Sherman Act when Plaintiffs sufficiently alleged that ABIM engaged in a range of anticompetitive conduct, including but not limited to tying. A-36-37.

(3) Whether the district court erred in concluding that Plaintiffs did not state a claim under RICO when Plaintiffs sufficiently alleged they were directly harmed by ABIM's scheme to defraud. A-39-40.

(4) Whether the district court erred in concluding Plaintiffs did not state a claim for unjust enrichment when Plaintiffs sufficiently alleged that ABIM forced Plaintiffs and other internists to buy MOC. A-41.

STATEMENT OF RELATED CASES AND PROCEEDINGS

This case has never previously been before this Court. No proceedings remain pending in the district court.

STATEMENT OF THE CASE

I. RELEVANT FACTS

Defendant American Board of Internal Medicine ("ABIM") has sold certifications to new residency program graduates since 1936. (¶ 22). [1] Certifications assess postgraduate medical education and training obtained through successful completion of residency programs. (¶ 21). Because no other vendor sells certifications, ABIM is the monopoly supplier. (¶¶ 2, 50, 51). Certifications are the tying product in Plaintiffs' claims under the Sherman Act. (¶ 3).

ABIM announced in 1990, that beginning in 2000 it would start selling maintenance of certification ("MOC") and told internists their certifications would be revoked unless they bought MOC. (¶¶ 4, 26-27, 44, 49, 61). According to ABIM's Form 990 filed with the Internal

[1] References to "¶ ___" are to paragraphs of the Amended Class Action Complaint ("Complaint"), included in the Appendix at A-42-92. After ABIM began selling MOC it changed its terminology for certifications and began referring to them as "initial certifications." The district court referred to "ABIM certification" and Plaintiffs likewise refer herein to "certifications" and "MOC."

Revenue Service ("IRS"), MOC "means something different" from certifications and "speaks to the question of whether or not an internist is staying current." (¶ 53). MOC is the tied product in Plaintiffs' claims under the Sherman Act. (¶ 4).

The forerunner to MOC, named "Continuous Professional Development Program" ("CPD"), was launched by ABIM in 1974. (¶ 25). This first CPD product was also meant to keep internists current, but was voluntary and ABIM did not revoke certifications if internists did not purchase it. (*Id.*). After several years of meager sales, ABIM re-branded its CPD product as MOC and began selling it in 2000, making it mandatory. (¶¶ 26-27). [2]

ABIM has carved out an exception for "grandfathered" internists who bought certifications before 1990, and who are not required to buy MOC to keep their certifications. (¶¶ 27-28). About 40% of internists, approximately 80,000 doctors, have been "grandfathered" by ABIM from the requirement to buy MOC. (¶¶ 5, 29). All other internists, however, are forced to purchase MOC throughout their careers or have their

[2] ABIM has changed MOC constantly over the years, increasing the burden and cost to internists. (¶¶ 31-34).

certifications revoked. (¶¶ 4, 26, 30, 37, 42, 61, 65, 68, 69, 71). "Grandfathers" may voluntarily buy MOC, but those who do so and fail to satisfy MOC's requirements do not have their certifications revoked by ABIM. (¶ 35). [3]

ABIM sells certifications and MOC separately and charges for them separately. (¶¶ 3, 4, 21, 30, 34, 52, 64, 143-144). New residency program graduates pay a one-time certification fee to ABIM upon graduation, and then later pay separate MOC fees throughout the remainder of their careers. (*Id*). Certification and MOC are not interchangeable or a component of one another. (¶ 52).

Certifications are an economic necessity, without which a successful medical career is impossible. (¶¶ 6, 37, 73, 155). Internists whose certifications are revoked by ABIM because they do not buy MOC are no longer eligible for admitting and other privileges by hospitals, health systems, practice groups, and medical corporations and/or lose employment. (¶¶ 37-38, 77-78, 88, 95-96, 109, 155, 166). Internists who lose hospital privileges because ABIM revokes their certifications also

[3] The ABIM CEO admits, "Grandfathering is a really vexing challenge. It's difficult to defend …" (¶ 27).

do not qualify for coverage under the hospital's malpractice policy and must purchase other more expensive insurance with less advantageous terms. (¶ 40).

Internists whose certifications are revoked by ABIM because they do not buy MOC are also no longer eligible to participate in insurance networks and cannot offer insurance coverage. (¶¶ 37, 39, 87, 95, 98, 155, 166). Their patients must either pay for treatment themselves or pay a higher "out of network" coinsurance rate, to the financial detriment of both the patient who must pay higher out-of-pocket costs, and the internist whose patient base is smaller due to the inability to offer insurance coverage. (¶ 39).

Other vendors sell products that like MOC keep internists current, including continuing medical education ("CME") products required for State medical licensure. (¶¶ 20, 54). MOC differs from CME, however, because if internists do not see value in a CME product they are free to purchase another CME product; there is no such option for MOC because internists are forced to buy MOC or have their certifications revoked. (¶ 54). Internists prefer to buy products from

others to keep current rather than being forced to buy MOC from ABIM. (¶¶ 55, 66).

The National Board of Physicians and Surgeons ("NBPAS") also sells a CPD product designed to keep internists current. (¶¶ 56-57). Like ABIM, NBPAS calls its product maintenance of certification. (¶ 56). To buy the NBPAS product, internists must, among other things, be ABIM-certified. (¶ 57). The NBPAS product costs significantly less than MOC. (*Id.*). NBPAS does not sell certifications. (¶¶ 56, 58).

As a result of its monopoly in certifications and forcing internists to buy MOC or have their certifications revoked, ABIM is able to charge inflated monopoly prices for MOC. (¶¶ 4, 64, 68). MOC fees have increased from $759 to $2,250 since ABIM began selling MOC in 2000. (¶ 143). This is substantially higher than the cost of CPD products sold by others. (¶ 57). One analysis projects that MOC costs internists an average of $23,607 in time and money over a ten year period, and that "[t]he 2015 MOC is projected to cost $5.7 billion [internal reference omitted] over the coming decade," including time costs resulting from 32.7 million physician hours. (¶ 36).

ABIM accounts for certifications and MOC separately on its financial statements. (¶¶ 144-147). MOC revenue almost tripled over the eleven years through 2017 to $24,637,595. (¶ 144). In 2006, MOC revenue was approximately 54% of certification revenue and about 35% of ABIM total revenue; by 2017, MOC revenue increased to 80% of certification revenue and 45% of ABIM total revenue. (¶ 145). [4]

ABIM has created a lucrative new revenue source by forcing internists to buy MOC. (¶ 148). The new MOC revenue has not been used in the interests of the internist community, but to serve the economic interests of ABIM management, including overly generous compensation, ABIM's lavish pension plan, and purchase of a $2.3 million condominium used by ABIM management. (¶¶ 132, 148-153, 164, 167).

ABIM falsely claims to the public, including hospitals, medical corporations and other employers, insurers, and the media, that MOC

[4] These data show certifications are a declining revenue source for ABIM, with MOC rapidly replacing it. (¶ 148). This is not surprising as new residency program graduates are often burdened with substantial debt and can afford only so much in certification fees; MOC, on the other hand, is imposed by ABIM on older internists who have the financial wherewithal to pay ever-increasing MOC fees. (*Id.*).

benefits physicians, patients, and the public and constitutes self-regulation. (¶¶ 6, 42-43, 94, 131, 133-135, 154, 166, 167). For example, ABIM misrepresents that MOC is "a reliable indicator of physician quality," there is "compelling evidence showing that MOC improves value of care without sacrificing quality," doctors who buy MOC "provide better patient care," and MOC assures the quality of physicians and patient safety. (¶¶ 134-135, 168c, 168d). ABIM knows these and similar representations are untrue. (¶¶ 136-142, 155-156, 163). There is no evidence of a causal relationship between MOC and any beneficial impact on physicians, patients, or the public. (¶¶ 42-43, 136). Nor does MOC constitute self-regulation by internists. (¶ 156).

Plaintiffs brings this Class Action on behalf of all internists who are forced by ABIM to buy MOC or have their certifications revoked. (¶¶ 7, 114-120). Plaintiffs each purchased certifications and are forced by ABIM to buy MOC or have their certifications revoked. (¶¶ 75, 83, 91, 104). None of the certifications relevant to Plaintiffs' claims are "grandfathered." (*Id.*). [5]

[5] For Plaintiffs' background and details of their personal claims, *see* Dr. Kenney (¶¶ 13, 74-80), Dr. Joshua (¶¶ 14, 81-89), Dr. Manalo (¶¶ 15, 90-102), and Dr. Murray-Leisure (¶¶ 16, 103-113).

Drs. Kenney and Manalo did not buy MOC and ABIM revoked their certifications. (¶¶ 80, 93, 102). Dr. Joshua bought MOC but did not pass a MOC test and ABIM revoked her certification. (¶ 85). Dr. Murray-Leisure bought MOC, did not pass a MOC test, and ABIM revoked her certification, but she passed later and ABIM reinstated her certification. (¶¶ 109, 111).

In addition to money damages, Plaintiffs ask that ABIM be enjoined from revoking certifications of internists who do not buy MOC. (¶ 7). Plaintiffs do not contend ABIM should be prevented from determining its own standards, or be required to accept any other CPD product as a substitute for certifications or MOC. There is no legitimate business or pro-competitive justification for ABIM's tying of certifications and MOC. (¶ 124).

II. PROCEDURAL HISTORY

Plaintiffs-Appellants filed their Class Action Complaint against Defendant-Appellee ABIM on December 19, 2018, in the Eastern District of Pennsylvania, alleging violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1, 2. Dkt. 1. On January 24, 2019, Plaintiffs filed an Amended Class Action Complaint adding claims for violation of

RICO, 18 U.S.C. § 1962(c), and unjust enrichment. A-42-92. ABIM moved to dismiss all counts of the Amended Complaint under Federal Rule of Civil Procedure 12(b)(6). Dkt. 22. On September 26, 2019, the district court issued a Memorandum opinion granting ABIM's motion to dismiss. A-7-41. By stipulation of the parties, a final judgment was entered on December 6, 2019. A-4. Plaintiffs filed their Notice of Appeal to this Court on December 30, 2019. A-1.

III. RULING PRESENTED FOR REVIEW

The ruling presented for review in this Court is the district court's granting of ABIM's motion to dismiss and dismissal of all counts of the Amended Class Action Complaint. A-7-41.

SUMMARY OF ARGUMENT

Plaintiffs allege ABIM violates Section 1 of the Sherman Act by illegally tying certifications (the tying product) and MOC (the tied product). Certifications are sold to new residency program graduates and assess postgraduate medical education and training. MOC, on the other hand, according to ABIM, "means something different" from certifications and "speaks to the question of whether or not an internist is staying current."

ABIM is the monopoly seller of certifications and if internists do not buy MOC, ABIM revokes their certifications. Internists whose certifications are revoked by ABIM because they do not buy MOC are no longer eligible for hospital admitting and other privileges, employment, insurance coverage, and other requirements necessary for the successful practice of medicine. ABIM uses its monopoly power over certifications to force internists to buy MOC or have their certifications revoked.

The district court dismissed the tying claims with prejudice, finding that certifications and MOC are not separate products. A-33. "Whether one or two products are involved turns … on the character of the demand for the two items." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 19 (1984). *Jefferson Parish* and its progeny set forth several factual indicia of separate demand governing the separate product analysis, and Plaintiffs have alleged facts supporting each such indicia. Plaintiffs allege: internists differentiate between certifications and MOC; ABIM has always sold them separately; ABIM treats the two products as separate; ABIM bills and accounts for certifications and MOC separately; and other vendors sell CPD products like MOC that keep internists current without selling certifications.

The district court ignored these allegations and erroneously concluded that certification and MOC are one product. A-29. In doing so it arrogated to itself determination of the ultimate factual issue, improperly weighed facts, resolved inferences against Plaintiffs, and considered "facts" asserted by ABIM outside the Complaint, all of which are improper on a motion to dismiss. *See Flora v. County of Luzerne*, 776 F.3d 169, 175 (3d Cir. 2015); *Kedra v. Schroeter*, 876 F.3d 424, 433 (3d Cir. 2017) ; *Sweda v. Univ. of Pa.*, 923 F.3d 320, 326 (3d Cir. 2019).

The district court dismissed the Plaintiffs' monopolization claims under Section 2 of the Sherman Act, finding "no anticompetitive conduct on the part of ABIM." A-36. Plaintiffs, however, allege a range of anticompetitive conduct by ABIM, in addition to tying, including: leveraging its monopoly in certifications; forcing internists to buy MOC; thwarting competition; placing market participants on its board of directors; waging a campaign of deception about the benefits of MOC; constantly making burdensome changes to MOC; monopoly pricing; and rendering internists unable to assess lifetime costs of MOC. (¶¶ 4-6, 26-27, 31-34, 37, 42, 44, 49-51, 55, 57, 59-65, 67-68, 70-71, 73, 127-129, 133-135).

Plaintiffs allege a simple and plausible RICO scheme: in order to generate MOC fees, ABIM fraudulently misrepresents MOC to convince hospitals, insurers, and others to require internists to buy MOC in order to obtain admitting and other privileges, employment, insurance coverage, and other requirements of the practice of medicine. The district court held Plaintiffs did not have standing because they failed adequately to allege that ABIM's RICO violations proximately caused their injuries. A-40.

Internists, however, are the targets of the RICO scheme, and have paid hundreds of millions of dollars in MOC fees to ABIM as a direct result of its campaign of deception. Hospitals, insurers, and others to whom the fraudulent statements were directed suffer no harm and have no reason to pursue claims against ABIM. Because Plaintiffs and other internists are the only persons harmed by ABIM's fraud, their injuries are not derivative of any other injury and Plaintiffs' have sufficiently alleged proximate cause. *See In re Avandia Mktg.*, 804 F.3d 633, 643-44 (3d Cir. 2015).

The district court held Plaintiffs' failed to allege one element of their unjust enrichment claim, concluding "it is not inequitable for

ABIM to keep the benefit [MOC fees] because it did not 'force' Plaintiffs to purchase MOC." A-41. Plaintiffs allege, however, that the economic reality is that ABIM, by revoking certifications of internists who do not buy MOC, render them no longer eligible for admitting and other privileges, employment, insurance coverage, and other requirements for the successful practice of medicine. Internists, thus, have no choice but to buy MOC, although they would prefer to purchase other products elsewhere to keep current. ABIM's inequitable conduct forcing these purchases, thus, adequately supports Plaintiffs' claim for unjust enrichment.

ARGUMENT

I. THE DISTRICT COURT ERRED BY DISMISSING THE TYING CLAIMS WITH PREJUDICE.

A. Standard Of Review.

This Court's "review of a district court's dismissal of a complaint for failure to state a claim is plenary." *Broadcom Corp. v. Qualcomm Inc.*, 501 F.3d 297, 306 (3d Cir. 2007). In reviewing a dismissal under Rule 12(b)(6), the Court "accept[s] all factual allegations as true, construe[s] the complaint in the light most favorable to the plaintiff, and determine[s] whether, under any reasonable reading of the

complaint, the plaintiff may be entitled to relief." *Id.* (internal citation omitted). In doing so, the Court views "reasonable inferences drawn from the [allegations] in the light most favorable to [Plaintiffs]." *Sweda v. Univ. of Pa.*, 923 F.3d 320, 326 (3d Cir. 2019).

B. Plaintiffs State A *Per Se* Tying Claim.

Tying "is *per se* illegal." *Eisai, Inc. v. Sanofi Aventis U.S., L.L.C.*, 821 F.3d 394, 405 (3d Cir. 2016). The elements of a *per se* tying claim are: "[W]here (1) a defendant seller ties two distinct products; (2) the seller possesses market power in the tying product market; and (3) a substantial amount of interstate commerce is affected, then the defendant's tying practices are automatically illegal without further proof of anticompetitive effect." *Town Sound & Custom Tops, Inc. v. Chrysler Motors Corp.*, 959 F.2d 468, 477 (3d Cir. 1992). [6] It is the

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[6] The district court enumerated four elements, not three:

> "(1) a defendant seller ties two distinct products; (2) the purchase of the tying product is conditioned on the sale of the tied product; (3) the seller possesses market power in the tying product market to coerce purchasers into buying the tied product; and (4) a not insubstantial amount of interstate commerce is affected."

"probable" exploitation of leverage in the market where the seller possesses market power that warrants use of a *per se* analysis. *Brokerage Concepts, Inc. v. U.S. Healthcare, Inc.*, 140 F.3d 494, 512-13 (3d Cir. 1998). [7]

Plaintiffs claim ABIM violates Section 1 of the Sherman Act by illegally tying certifications and MOC. Neither the district court nor ABIM challenged the economic plausibility of Plaintiffs' tying claim, for it makes perfect sense that a monopolist such as ABIM would leverage its market power in a tying product (certifications) to gain an advantage in a tied product (MOC). *See Eastman Kodak Co. v. Image Technical Services, Inc.*, 504 U.S. 451, 478 (1992) (use of monopoly power in tying product to gain advantage in tied product "facially anticompetitive").

Internists do not purchase MOC because it is better-quality (it does not result in better patient care) or is lower-priced (it is more

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A-26-27 (internal quotation marks and citations omitted). The second element, however, is redundant of the first, and another articulation of the required tie.

[7] ABIM did not contest for purposes of the motion to dismiss that Plaintiffs sufficiently allege it possesses monopoly power in the tying product (certifications) and that a substantial amount of interstate commerce is affected. (¶¶ 2, 10, 36, 50, 51, 144, 147).

costly) than other CPD products. Internists buy MOC because ABIM uses its monopoly power over certifications to present them with a Hobson's choice: either buy MOC from ABIM or have the certifications required to successfully practice medicine revoked. This forcing is readily apparent from ABIM's earlier, unsuccessful CPD product.

When ABIM offered what it candidly called its "Continuous Professional Development Program," certifications were not revoked if doctors did not buy the CPD product. This voluntary CPD product, however, was met with rampant indifference by internists. Years later, ABIM, much less candidly, re-branded its "Continuous Professional Development Program" as maintenance of certification, or MOC. But rather than being voluntary, ABIM instead leveraged its monopoly in certifications. Unless doctors bought MOC, ABIM revoked their certifications.

Certifications and MOC are distinct products. As detailed below, Plaintiffs allege that internists differentiate between certifications and MOC; ABIM has always sold them separately; ABIM treats the two products as separate; ABIM bills and accounts for certifications and MOC separately; and other vendors sell CPD products like MOC

without certifications, showing it is efficient to provide them separately. Certifications and MOC are functionally different. There are no efficiencies from bundling certifications and MOC, or inefficiencies from others selling CPD products separately.

1. The District Court Misconstrued the Complaint.

The district court addressed only one element of Plaintiffs' tying claim, finding as a matter of law that certifications and MOC are not distinct products. But its fundamental premise is flawed. The district court began by recharacterizing what it viewed as the "essence" of Plaintiffs' claim. A-29. According to the court, "In essence, Plaintiffs are arguing that, in order to purchase ABIM's initial certification, internists are forced to purchase MOC products as well." *Id.*

But the district court had it backwards. Having first purchased certifications, internists are later forced by ABIM to buy MOC or have their certifications revoked. The court's belief that tying requires sale of the tying and tied products in the same transaction is erroneous. Whether sales are simultaneous or sequential is not "decisive of the legal test for separate products." Philip E. Areeda & Herbert Hovenkamp, *Antitrust Law: An Analysis of Antitrust Principles and*

Their Application, ¶ 1751b, at 286 (4th Ed. 2018) ("Areeda & Hovenkamp").

The district court cited prominently to *Kaufman v. Time Warner*, 836 F.3d 137 (2d Cir. 2016), which had not been cited by the parties below. A-27-28. The Second Circuit held there that a third amended complaint failed to allege facts supporting separate demand for cable programming (tying product) and cable boxes (tied product). Instead, plaintiff had alleged unhelpful "supply-side considerations," referred to inapposite markets outside the United States, and analogized to a disparate product. 836 F.3d at 144-45. In reaching its conclusion, the Second Circuit placed great emphasis on the regulatory role played by the FCC, noting that price controls on the tied product made the tying claim "implausible as a whole." *Id*. at 145-47. [8]

The district court highlighted *Kaufman's* analogy that the cable boxes were like "keys to a padlock," *id*. at 144, but did not explain how it applies here. A-28. It does not. Cable programming and cable boxes

[8] FCC regulations also mandated that the charges for programming and the boxes be itemized separately. *Id*. at 146. There is no such requirement to justify disregarding ABIM's separate billing and accounting for certifications and MOC.

are technologically interdependent, the boxes being necessary to unscramble the cable signal to deliver the programming. There is, however, no interdependence, technological or otherwise, between certifications and MOC (¶ 52), and no connection at all other than ABIM's illegal tie. Nor do Plaintiffs contend ABIM should be prevented from determining its own standards, or be required to accept any other CPD product as a substitute for certifications or MOC. Plaintiffs ask only that ABIM not revoke certifications of internists who do not buy MOC. (¶ 7).

Because the reasoning in *Kaufman* does not apply here, the district court's reliance was inappropriate. There are no "regulatory price controls" on ABIM that make Plaintiffs' claims economically implausible. Plaintiffs have also pled facts not pled in *Kaufman* showing separate demand. The district court rejected these allegations but in doing so, as discussed in detail below, it ignored or distorted them, improperly weighed them, wrongfully resolved inferences in favor

of ABIM and against Plaintiffs, and considered "facts" asserted by ABIM outside the Complaint. [9]

The district court held, "We disagree with Plaintiffs *and find* that ABIM's certification and MOC products are part of a single product." A-29 (emphasis added). This is clear error. *Flora v. County of Luzerne*, 776 F.3d 169, 175 (3d Cir. 2015) ("The district court may not make findings of fact"). The court went on to conclude: "[W]hat internists are *actually buying* is ABIM certification" rather than certifications and MOC. A-29 (emphasis added). In making these fact determinations, the district court erroneously adopted ABIM's unsubstantiated thesis, contradicted by Plaintiffs' factual allegations, that certifications and MOC constitute a unified product. *See Kedra v. Schroeter*, 876 F.3d 424, 433 (3d Cir.

[9] Another district court applying *Kaufman* denied a motion to dismiss a tying claim, citing allegations like those here that the two products were purchased separately reflecting separate demand, and that plaintiff had as a result "sufficiently pled the element of separate products." *Angio Dynamics, Inc. v. C.R. Bard, Inc.*, No. 1:17-cv-00598, 2018 U.S. Dist. LEXIS 131206, *19-23 (N.D.N.Y. Aug. 6, 2018). The district court in *Viamedia, Inc. v. Comcast Corp.*, 335 F. Supp. 3d 1036, 1059 (N.D. Ill. 2018), relied on *Kaufman* in granting summary judgment to defendant on a Section 2 claim asserting illegal tying. That decision was recently reversed. *Viamedia, Inc. v. Comcast Corp.*, 951 F.3d 429 (7th Cir. 2020).

2017) (district court erred in granting motion to dismiss when it "accepted both [defendant's] premise and conclusion").

Contrary to the district court's supposition, just because ABIM's illegal tie has succeeded does not disprove separate demand. As alleged, internists buy MOC not because they conflate certifications and MOC, but because ABIM forces them to buy MOC by revoking certifications if they do not. In *Viamedia,* 951 F.3d at 469, the Seventh Circuit rejected defendant's argument of a single product premised on an assessment after the tie was already in place. (*Citing* Areeda & Hovenkamp ¶1802d6, at 89). Here, demand must also be assessed before MOC was introduced rather than after, when ABIM enforced its illegal tie by making MOC mandatory.

The district court assumed there is one product without any basis other than its unsupported conclusion that internists are "actually buying" ABIM certification rather than certifications and MOC. In doing so it arrogated to itself determination of the ultimate factual issue, and simply took as true ABIM's arguments rather than Plaintiffs' factual allegations to the contrary. A proper reading of the Complaint taking all well-pled allegations as true and construing all inferences in

their favor confirms Plaintiffs have alleged facts showing certifications and MOC are separate products and have also alleged all other elements of a *per se* tying claim. Thus, dismissal was erroneous and should be reversed.

2. The Complaint Alleges Well-Pled Facts Supporting Separate Products.

"Whether one or two products are involved turns … on the character of the demand for the two items." *Jefferson Parish Hosp. Dist. No. 2 v. Hyde*, 466 U.S. 2, 19 (1984). Courts look at whether the products are "distinguishable in the eyes of buyers" and "separately priced and purchased from the buyer's perspective." *Id.* at 19-20. Courts also examine market structure and practices: "[A] tying arrangement cannot exist unless there is sufficient demand for the purchase of the tied product separate from the purchase of the tying product so as to identify a market structure in which it is efficient to offer the tied product separately from the tying product." *Allen-Myland, Inc. v. IBM Corp.*, 33 F.3d 194, 211 (3d Cir. 1994) (reversing summary judgment for defendant on tying claim citing evidence of separate demand).

a. The Complaint alleges consumers differentiate between certifications and MOC.

Courts look to whether consumers "differentiate between" the tying and tied products as evidence of separate products. *Jefferson Parish*, 466 U.S. at 22-23 ("Unquestionably," anesthesiological and other hospital services "could be provided separately" and "patients or surgeons often request specific anesthesiologists to come to a hospital and provide anesthesia"); *Viamedia,* 951 F.3d at 469 (buyers "viewed the services as separate").

Plaintiffs allege numerous facts showing consumers (internists) differentiate between certifications and MOC. *E.g.*, ¶¶ 55, 66 (internists prefer to purchase CPD products like MOC separate from certifications); ¶ 25 (some internists bought ABIM's voluntary CPD product separate from certifications); ¶¶ 27-29, 35 ("grandfathers" given the choice do not buy MOC); ¶¶ 20, 54, 56-57 (internists keep current by buying CPD products other than MOC from vendors who do not sell certifications); ¶ 54 (CME serves same function as MOC and is bought by internists separate from certifications); ¶¶ 87, 89 (Dr. Joshua purchased NBPAS product separate from certifications); ¶ 95 (Dr.

Manalo sought to purchase CME products separate from certifications as substitute for MOC); ¶ 113 (Dr. Murray-Leisure attempted to have NBPAS product separate from certifications accepted). Especially probative is the fact that ABIM exempts "grandfathers" from the requirement to buy MOC. (¶¶ 27-28). That thousands of internists forsake MOC while buying other CPD products from CME vendors for State licensure purposes confirms they differentiate between certifications and MOC. (¶ 20).

Rather than accept these factual allegations as true, the district court ignored them, chose to "find" a single product, and concluded Plaintiffs "misunderstand the product being offered." A-31. Plaintiffs did not misunderstand the product. Rather, the court misunderstood the nature of the exercise on a motion to dismiss, which is to determine only whether the complaint alleges facts necessary to state a plausible claim. ABIM chose to deflect and distract by advancing outside-the-record theories about its products. It was error for the district court to allow ABIM to divert its attention from the question it was tasked to resolve.

The district court also held that ABIM "has the right to ensure [its] standards are met." *Id*. This mistakenly looks at the products not from the consumer's perspective, but from ABIM's own partisan orientation. Whether from ABIM's viewpoint MOC has anything to do with asserted standards is not germane to whether internists differentiate between certifications and MOC. To the contrary, from the internists' perspective, MOC is imposed to generate additional revenue for ABIM and has nothing to do with standards. (¶¶ 30, 44, 65, 94, 143-147, 148, 156, 163-164). The court's unquestioned acceptance of ABIM's "standards" pretext for its anticompetitive conduct is both outside of and at odds with Plaintiffs' allegations and clear error.

See Flora, 776 F.3d at 175; *Sweda*, 923 F.3d at 333; *Kedra*, 876 F.3d at 433. [10]

b. The Complaint alleges ABIM sells certifications and MOC separately.

Separateness is satisfied by evidence that the two products "have been sold separately in the past and still are sold separately." *Eastman Kodak*, 504 U.S. at 462 (1992). *See also Multistate Legal Studies, Inc. v.*

[10] As discussed below, crediting ABIM's business justification affirmative defenses was itself reversible error. *See* pp. 43-48, *infra*.

Harcourt Brace Jovanovich Legal and Prof'l Publ., Inc., 63 F.3d 1540, 1547 (10th Cir. 1995) (products marketed separately "for over a decade" and still sold separately).

ABIM has sold certifications from 1936 to the present. (¶ 22). It did not sell MOC or any other CPD product for most of that time, during which other vendors sold CPD products such as CME separate from certifications. (¶¶ 20, 25, 54). ABIM's first CPD product (its voluntary "Continuous Professional Development Program") was sold separately from certifications. (¶ 25). ABIM continues to sell its CPD product separately after re-branding it as MOC. (¶¶ 26-27).

The district court discounted Plaintiffs' allegations that ABIM sold certifications and MOC separately as "misleading" because "history shows that MOC has been a requirement of ABIM certification for longer than it has not." A-31. First, that is simply wrong. In 1990, ABIM announced that, except for those it "grandfathered," internists beginning in 2000 would have to buy MOC or have their certifications revoked. (¶¶ 26-27). Thus, ABIM has sold certifications from 1936 to the

present, eighty-four years, and only announced it would begin requiring MOC in 1990, with sales beginning in 2000. [11]

Second, precisely when ABIM began its illegal tying by requiring MOC is irrelevant to whether certifications and MOC have been sold separately. They have. Third, the district court admittedly weighed Plaintiffs' allegations of separate sales, giving "very little weight in Plaintiffs' favor in our analysis." A-31. It is reversible error to weigh allegations on a motion to dismiss. *Anjelino v. The N.Y. Times Co.*, 200 F.3d 73, 97 (3d Cir. 2000) ("Rather than weighing the credibility of the parties' positions on this disputed issue, the District Court should under Rule 12 (b)(6) and Rule 56 have left such considerations to a jury."). *See also Sweda*, 923 F.3d at 333; *Kedra*, 876 F.3d at 433. That error is especially problematic here given the court was wrong that MOC has been a requirement of certification for longer than it has not.

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[11] The district court either got its math wrong or mistakenly believed MOC has been sold continuously since 1974-75. A-30-31. But 1974-75 was when ABIM began selling not MOC, but its voluntary "Continuous Professional Development Program." ABIM sold no other CPD product until MOC was announced in 1990, and sales began in 2000. (¶¶ 25-27). Contrary to the court's impression, the "Continuous Professional Development Program" was voluntary and never a requirement of certification.

c. The Complaint alleges ABIM treats certifications and MOC as separate.

According to the IRS Form 990 filed by ABIM, MOC "means something different from initial certification." (¶ 53). This allegation is telling because ABIM is managed by internists. (¶ 71). The district court gave no heed to this allegation. ABIM's own recognition that MOC "means something different" further demonstrates that internists, including those in charge of ABIM, differentiate between certifications and MOC. ABIM's "grandfather" policy similarly concedes that certification and MOC are distinct. (¶¶ 27-28). If MOC were one component of a single product, ABIM would not exempt thousands of certified internists from the requirement to purchase MOC. *See Viamedia*, 951 F.3d at 474 (defendant's sales of tying product alone show there "are indeed separate products").

The district court failed to accept these allegations as true, countering that "Plaintiffs provide no support as to why ABIM should not be allowed to modify its certification process over time," and concluding, "We see no problem that at some point ABIM realized there was a need to have its certified internists undergo an [sic] MOC program whether because the internists could not keep up with the

advances in their particular field, saw their skills diminish, or any other reason." A-33. The Complaint, however, includes no allegation that ABIM "realized there was a need" to modify certifications, that MOC even is a modification or an improvement, or that internists could not keep current. Nor are these permissible inferences from Plaintiffs' allegations. Instead, they are more outside-the-record contentions by ABIM adopted wholesale by the district court. [12]

Contradicting these unsupported conjectures, are Plaintiffs' factual allegations that: (1) rather than MOC being a modification or improvement, certifications and MOC are functionally different and "not interchangeable or a component of one another" (¶ 52); (2) there is

[12] The district court inferred from two Plaintiffs' failure to pass a MOC test that ABIM's tie was justified. A-33. The court twisted the allegations, however, which far from providing justification, further demonstrate MOC does not provide any benefit to physicians, patients, or the public. Dr. Joshua failed a MOC test and her certification was revoked; yet her patients were then treated by another doctor not required to buy MOC. (¶¶ 85, 86). MOC clearly was not required to assure that the doctor treating Dr. Joshua's patients kept current. Dr. Murray failed a MOC test in 2009 and then passed it in 2012. In the interim, she notified ABIM of serious deficiencies in MOC, including erroneous answers in a practice module and the lack of questions on infectious diseases common to the practice of most infectious disease physicians. (¶¶ 109-111). These and other inferences by the court against Plaintiffs were unreasonable and improper.

no legitimate business or pro-competitive justification for MOC, an artificial product created by ABIM to generate cash when its certification revenues began to diminish (¶¶ 44, 124, 148); (3) internists had for decades kept current without MOC by purchasing CPD products sold by others, including CME (¶¶ 20, 54); and (4) there is no evidence of a causal relationship between MOC and any benefit to physicians, patients, or the public, confirming MOC is a failed product that does not serve the needs or provide the benefits claimed by ABIM. (¶¶ 42-43, 136).

The district court ignored these allegations. Not only did the court wrongfully embrace ABIM's conclusory rhetoric, it misapplied the law. Even if MOC were viewed as a modification or improvement, which it is not, that would by no means be conclusive of whether a single product exists. Areeda & Hovenkamp, ¶ 1746, at 231 ("However, innovation need not always take the form of building a better mousetrap. Instead, the 'innovation' may be an anticompetitive tie that no one has tried before."); *id.* ¶ 1744h, at 200 (noting "the unremarkable view that things can be separate products even if they are complements").

For example, in *Multistate Legal Studies*, summary judgment in favor of defendants on a tying claim was reversed because a fact question existed whether a new workshop (the tied product) tied by defendants to their bar review course (the tying product) was distinct. Like here, defendants argued the workshop was "nothing more than the improvement of a single product." 63 F.3d at 1547. The district court agreed with defendants, finding that adding an improvement "could not possibly" constitute tying of a second product to the first product. *Id.* The Tenth Circuit, however, found "a material factual dispute" over whether there was sufficient demand for the course without the workshop "to make it efficient to sell the two separately." *Id.* at 1548.

Many of the facts relied upon in *Multistate Legal Studies* to reverse summary judgment are alleged by Plaintiffs here, including that defendants there did not require all purchasers of the course to buy the workshop, just as ABIM does not require "grandfathers" to buy MOC. Other allegations analogous to those here include a history of the two products being sold separately; separate fees; before defendants required purchase of the workshop, purchasers of the course chose not to buy it (similar to internists who chose not to buy ABIM's voluntary

CPD product and to "grandfathers" who choose not to buy MOC); and other industry participants viewed the two products as separate. *Id.* at 1547-48.

d. The Complaint alleges ABIM bills and accounts for certifications and MOC separately.

Courts also consider whether the tied product is billed separately. *Jefferson Parish*, 466 U.S. at 22 ("anesthesiological services are billed separately"); *Multistate Legal Studies,* 63 F.3d at 1547 (separate fees); *Thompson v. Metro. Multi-List, Inc.*, 934 F.2d 1566, 1575 (11th Cir. 1991) (same). ABIM has always sold certifications and MOC separately, and charged for them separately. (¶¶ 3, 4, 21, 30, 34, 52, 64, 143-144). ABIM also accounts separately for certifications and MOC on its financial statements. (¶¶ 144-148).

The district court, however, did not accept these allegations, concluding *Jefferson Parish* did not apply because there, "both services were part of the same transaction." A-32. Thus, the court found it determinative that, "[T]here is no indication in the Amended Complaint that the internists purchase their initial certification at the same time they purchase their MOC programs." *Id.* Once again, however, the

district court erroneously assumed an illegal tie requires that the products be sold as part of the same transaction. *See* pp. 19-20, *supra*.

Jefferson Parish concluded there was no illegal tying due to a lack of market power in hospital services; whether both products were part of the same transaction was not a factor. 466 U.S. at 26-28. To the contrary, the Supreme Court found that billing anesthesiological services separately, "amply support[ed] the conclusion that consumers differentiate between anesthesiological services and the other hospital services" without mandating that the products be sold in the same transaction. *Id.* at 23.

The district court distinguished *Thompson,* even though the Eleventh Circuit cited separate billing practices as "evidence of separate services," because the services were provided by different entities. A-32. The district court, however, did not explain why that distinction is significant. It is not. The entities were a parent and its subsidiary, and *Thompson* attached no significance to there being two, albeit related, entities. 934 F.2d at 1570, 1574-76. In fact, illegal tying cases typically involve a single seller. *See* Areeda & Hovenkamp, ¶ 1700, at 4 ("Tying occurs when a *seller* refuses to sell a product … unless the buyer also

agrees to purchase a second product … from *this seller*") (emphasis added). [13]

e. The Complaint alleges other vendors sell CPD products without certifications.

Courts also examine market structure and practices as an indication whether there are efficiencies to offering the products separately, thus supporting separate demand. *See Eastman Kodak*, 504 U.S. at 462 ("service and parts have been sold separately in the past [by others] and are still sold separately"); *Jefferson Parish*, 466 U.S. 23, n. 39 ("other hospitals often permit anesthesiological services to be purchased separately"); *Viamedia*, 951 F.3d at 469 (competitor offered only the tied product "for almost two decades"). *See also* Areeda & Hovenkamp, ¶ 1745c, at 202 (the Supreme Court in *Jefferson Parish* and *Eastman Kodak* "inferred the efficiency of bundling and nature of consumer demand indirectly from such more readily observed facts as actual consumer requests and market practices").

[13] The district court ignored altogether that in addition to billing internists separately, ABIM also accounts for certifications and MOC separately on its financial statements.

Other vendors sell CPD products without selling certifications. (¶¶ 2, 20, 50, 51, 56-57). The district court, however, either misunderstood or ignored these allegations. For example, it noted that ABIM and NBPAS do not sell the same product because ABIM does not revoke certifications if internists buy MOC. A-31-32. But that is precisely the point: ABIM illegally ties certifications and MOC. Once the illegal tie is stripped away in other words, but for ABIM forcing internists to purchase MOC, the NBPAS product and MOC are both CPD products separate from certifications.

The district court rationalized that other vendors sell CPD products without selling certifications by analogizing ABIM to a university with the "right to ensure that students who earn a degree have met set certain requirements set by that university." A-31. The analogy fails on several levels. First, Plaintiffs are not challenging ABIM's requirements for certifications it sells to new residency program graduates. Second, ABIM possesses monopoly power over certifications; by contrast, there are thousands of universities and colleges. Third, students are not required to pay their university for repeated examinations throughout their careers or forfeit their degrees. And

finally, students who go on to earn a graduate degree do not have their undergraduate degrees revoked when the graduate degree is obtained from a different university.

f. The Complaint alleges ABIM forces internists to buy MOC.

Certifications are essential for an internist to practice medicine successfully. (¶¶ 6, 37-38, 39, 40, 73, 77-78, 87, 95-96, 109, 155, 166). Given this reality and that ABIM revokes certifications of those who do not buy MOC, internists are forced to buy MOC. (¶¶ 4, 26, 30, 37, 42, 61, 65, 68, 69, 71). Internists, however, would rather buy CPD products from others. (¶¶ 55, 66). MOC cannot be considered voluntary, especially as a matter of law at this early stage of the proceedings. [14]

Courts recognize that economic reality, not rhetoric, dictates whether a purchase is forced. Thus, in *Viamedia* the Seventh Circuit found forcing to be a fact issue. 951 F.3d at 470-74 ("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). The Court specifically held

[14] ABIM's "Continuous Professional Development Program," its first CPD product, was truly voluntary. It failed. (¶ 25).

that the purported option of retail cable providers bringing the tied product (ad rep services) in-house was "not a practical choice," and that it "[c]annot affirm summary judgment by overlooking [the] evidence about the realities of the parties' dealings and the economic realities of the market." *Id*. at 470, n. 17.

So too here, as alleged, the purported option offered by ABIM that internists can refuse to buy MOC and still continue practicing after their certifications are revoked defies economic reality and is not a "practical choice." *See also Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 760 (1984) (Sherman Act "aimed at substance rather than form"); *Collins Inkjet Corp. v. Eastman Kodak Co.*, 781 F.3d 264, 272 (6th Cir. 2015) ("Unlawful ties need not be explicit …"); *United States v. Microsoft Corp.*, 253 F.3d 34, 64 (D.C. Cir. 2001) (en banc) (monopolist barring cost-effective means of distribution liable despite other means remaining open). *See* Areeda & Hovenkamp, ¶ 1752e, at 295 (tying present when defendant utilizes a customer's desire to "constrain improperly their choice" between products).

3. The District Court Used a Prohibited Functional Analysis to Find a Single Product.

Certifications and MOC are functionally distinct. Certifications are sold only to new residency program graduates, and according to ABIM demonstrate "that physicians have completed internal medicine and subspecialty training." (¶ 21). MOC on the other hand, is sold to established internists and, again according to ABIM, "means something different" and, "speaks to the question of whether or not an internist is staying current." (¶ 53). The district court failed to take into account these allegations of functional difference.

Making matters worse, the district court found as a matter of law that certifications and MOC were functionally linked. *See* A-23, A-33 ("what internists are actually buying is ABIM certification" not certifications and MOC, and "Plaintiffs provide no support as to why ABIM should not be allowed to modify its certification process over time"). In doing so, the court not only failed to take as true Plaintiffs' allegations of functional difference (and ABIM's admissions in its IRS Form 990), it applied a functional analysis rejected by the Supreme Court. *See Jefferson Parish*, 466 U.S. at 19 n.30 (whether products "are

functionally linked … is not in itself sufficient" to determine whether they are separate). [15]

When a court eschews the factors relevant to assessing demand in favor of divining the "nature" of the products on its own, as the district court did here, it errs as a matter of law. *See* Areeda & Hovenkamp, ¶ 1741a, at 170 ("Courts often decide whether two allegedly tied items 'really' constitute a single product as if the question involved natural law, intuition, or some other inquiry divorced from the aims of tying law … Such metaphysical or intuitive inquiries are inherently uncertain and are typically useless for analyzing ties.").

In *Service & Training, Inc. v. Data Gen. Corp.*, 963 F.2d 680 (4th Cir. 1992), plaintiff alleged Data General tied a diagnostic product to computer maintenance services. The district court concluded the diagnostic product "is merely one feature" of the unified "computer servicing" product, which it decided was the product consumers truly desired. It also found that the "only … legitimate purpose" for the tied

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[15] ABIM might be free to modify the "certification process" used to test new residency program graduates, but that is not at issue here. ABIM is not free to invent a wholly new product, even under the guise of a modification or improvement, and force internists to buy the new product throughout their careers or have their certifications revoked.

product was to "maintain and repair computer systems," and that since the two products "are inextricably bound together," they cannot be considered separate. *Id.* at 684. The Fourth Circuit reversed, calling "[t]his inquiry into purpose and use" by the district court "indistinguishable from the inquiry into the 'functional relationship' between products that was rejected in *Jefferson Parish*." *Id. See also Multistate Legal Studies,* 63 F.3d at 1551-52 (rejecting argument that incorporating a "product improvement" creates a single product because demand rather than related function is proper analysis).

Moreover, even products that are functionally linked can be separate products. *Jefferson Parish*, 466 U.S. at 19 n.30 ("[w]e have often found arrangements involving functionally linked products at least one of which is useless without the other to be prohibited tying devices") (collecting cases); *Viamedia,* 951 F.3d at 469 ("[t]he fact that buyers may wish to purchase and use two complementary products together does not, in and of itself, convert the two separate products into a single product"); *Thompson*, 934 F.2d at 1575 (argument "that multilist services are useless without the support services provided by the Realtors" rejected as "irrelevant" to whether the products are

separate). *See also* Areeda & Hovenkamp, ¶ 1751a2, at 280, 281 (asking whether buyer "needs both items to produce the system result the buyer really values" is misguided and "departs greatly from precedent … [t]he more accurate question is not whether the buyer 'needs both' products, but rather whether it 'needs both' from the same seller").

4. The District Court Erroneously Credited ABIM's Business Justification Affirmative Defenses.

Plaintiffs allege there is no legitimate business or pro-competitive justification for ABIM's tying of certifications and MOC. (¶ 124). The district court nonetheless unabashedly adopted ABIM's arguments that MOC is vindicated by claimed business justifications, including:

- "hospitals, insurance companies, and patients would lose faith in the ABIM certification process" if internists were not required to buy MOC,
- ABIM "has the right to ensure [its] standards are met," and
- "ABIM realized … internists could not keep up" with advances.

A-30 n.2, A-31, A-33. While there is no basis in the Complaint for these findings by the court, each was advocated by ABIM below. *See, e.g.*, Dkt. 22-2 at 8-9, 12, 19. [16]

There is no allegation in the Complaint that anyone would lose faith in ABIM if its illegal tying of MOC were stripped away. In fact, Plaintiffs allege the opposite, that ABIM is itself "undermining the credibility of MOC." (¶ 34). *See* Areeda & Hovenkamp, ¶ 1761, p. 400-401 (the question is whether the tie "is needed at all protect a product's reputation."); *id.* at ¶ 1716b, p. 197 ("many decisions, including several by the Supreme Court, have rejected quality-control defenses because the challenged tie did not seem necessary to protect quality."). Nor do

[16] Although the district court in some instances cited to allegations in the Complaint when reaching its conclusions, it necessarily twisted them to do so. For example, the court cited ¶¶ 32-34 as support for its finding that MOC "allows ABIM to ensure that those it has certified are still able to meet its 'rigorous standards' and stay up-to-date on the general practice of internal medicine." A-30. But those allegations contain no reference to "rigorous standards" and simply describe how ABIM has lurched from one ineffective incarnation of MOC to another and by doing so increased costs to internists. The reference to "rigorous standards" is from ABIM's Form 990 and specifically refers to certifications and *not* MOC. (¶ 21). At minimum, the district court repeatedly and wrongfully resolved inferences in favor of ABIM and against Plaintiffs.

Plaintiffs propose ABIM must accept other CPD products in place of MOC, a misapprehension that pervades the district court's opinion.

There is likewise no allegation in the Complaint that MOC ensures ABIM "standards." Plaintiffs assert the opposite: that the driving force behind MOC is the substantial new revenue it generates; that it "undermin[es] the credibility" of ABIM; and that there is no evidence of a causal relationship between MOC and any benefit to physicians, patients, or the public. (¶¶ 34, 42-43, 44, 65, 136, 164). And again, Plaintiffs do not contend ABIM should be prevented from determining its own standards.

As to internists not being able to keep current without MOC, that allegation also appears nowhere in the Complaint. Further, as *Jefferson Parish* made clear, "we reject the view of the District Court that the legality of an arrangement of this kind turns on whether it was adopted for the purpose of improving patient care." *See also* Areeda & Hovenkamp, ¶ 1741b, at 174 ("The separate-products requirement is not an invitation to examine the general reasonableness of the bundle.").

Not only was the district court's adoption of ABIM's affirmative defenses contrary to Plaintiffs' allegations, it was error for the court even to consider them. *See Jefferson Parish*, 466 U.S. at 26, n.42 (defendant's "goodwill" justification for tie and similar arguments are "defenses"); *Mozart Co. v. Mercedes-Benz of North America, Inc.*, 833 F.2d 1342, 1349 (9th Cir. 1987) (argument that "tying arrangement is necessary to assure quality control and to protect its goodwill" an "affirmative defense" for which defendant bore burden of proof) (internal quotation omitted); *Metrix Warehouse, Inc. v. Daimler-Benz Aktiengesellschaft*, 828 F.2d 1033, 1040 (4th Cir. 1987) (same). *See also* Areeda & Hovenkamp, ¶ 1741, at 175 ("Justifications can be considered as a defense to a tying claim, and normally are now so considered by courts.").

A plaintiff is not required to anticipate and plead around affirmative defenses. "Generally speaking, we will not rely on an affirmative defense … to trigger dismissal of a complaint under Rule 12(b)(6)." *Victaulic Co. v. Tieman*, 499 F.3d 227, 234 (3d Cir. 2007). There is a "particularly heavy burden" on a defendant when, as here, the defense asserted is highly fact intensive. *Id.* at 235 (affirmative

defense of "unreasonableness … is a factual one, requiring consideration of all the facts and circumstances"). *See also*, *id.* at 237 ("drawing inferences against the non-moving party so as to dismiss its well-pleaded claims on the basis of an affirmative defense, takes us, as a matter of process, far too far afield from the adversarial context of litigation"). Basing dismissal on ABIM's affirmative defenses was reversible error.

In a footnote, the district court found the franchise model advocated by ABIM, while "not a perfect comparator," to be "very instructive." A-30, n.2. To the contrary, the model is inapposite and not at all instructive. First, ABIM is a monopolist with market power in certifications who forces internists to buy MOC by revoking their certifications if they do not. Franchisors, on the other hand, are not monopolists, and franchisees are free to choose from any number of franchise opportunities. Bundling of products in the franchise context is contractual in nature, agreed to as part of the franchise documents, and not founded on anti-competitive coercion.

In *Queen City Pizza, Inc. v. Domino's Pizza, Inc.*, 124 F.3d 430, 441 (3d Cir. 1997), this Court explained that the "franchise package"

there was "consistent with the existence of a competitive market in which franchises are valued, in part, according to the terms of the proposed franchise agreement and the availability of alternative franchise opportunities. Plaintiffs need not have become Domino's franchisees." It went on to recognize, however, that market power in the tying product, as ABIM possesses here, would result in a different outcome: "If Domino's had market power in the overall market for pizza dough and forced plaintiffs to purchase other unwanted ingredients to obtain dough, plaintiffs might possess a valid tying claim." *Id.* at 443.

In addition, internists do not purchase licensing rights from ABIM, share investment risk with ABIM, or buy a uniform method of doing business from ABIM. Thus, the economic rationale that certain efficiencies might justify a franchisor's bundling does not apply here. *See* Areeda & Hovenkamp, ¶ 1710c3, at 117 (in franchise cases, "the tie is being used not to extract monopoly prices or drive out competitors, but rather as a mechanism by which the franchisor and franchisee share the risk of investment and operations"). The franchise analogy is specious and the district court erred by adopting it from ABIM.

C. Plaintiffs State A Rule of Reason Tying Claim.

A rule of reason analysis comes into play only when "appreciable tying market power cannot be shown." *Brokerage Concepts*, 140 F.3d at 511. Because ABIM's monopoly power in certifications is not disputed for present purposes, whether Plaintiffs' alternative rule of reason tying allegations state a claim need not be considered at this time. In addition, whether a *per se* or rule of reason analysis is warranted is best determined not on the pleadings but after consideration of a full evidentiary record. *See Eastman Kodak* 504 U.S. at 466–67.

Notwithstanding, to state a rule of reason tying claim a plaintiff, in addition to the *per se* elements, must allege the tie "unreasonably restrained competition" in the tied product. *Brokerage Concepts*, 140 F.3d at 511. The Complaint alleges well-pled facts showing ABIM has unreasonably restrained competition. For example, internists prefer to purchase CPD products from others to keep current (¶¶ 55, 66), but are forced to buy MOC (¶¶ 4, 26-27, 44, 49, 61). This includes CME products that serve the same function as MOC. (¶¶ 20, 54). Dr. Manalo sought unsuccessfully to purchase CME products as a substitute for MOC. (¶ 95). NBPAS also sells a CPD product, though ABIM's illegal

tying of certifications and MOC has led to "limited success" by NBPAS and eliminated "meaningful competition." (¶¶ 56, 59, 68).

By forcing internists to buy MOC, ABIM shuts out competitors and unreasonably restrains competition in the tied product. As a result, Plaintiffs and other internists are forced to buy MOC at inflated monopoly prices or have their certifications revoked. (¶¶ 4, 64). There is no legitimate business or pro-competitive justification for ABIM's tying of certifications and MOC. (¶ 124).

Plaintiffs allege sufficient facts to demonstrate that ABIM's restraint of competition is unreasonable. *See Arizona v. Maricopa County Medical Society*, 457 U.S. 332, 343 (1982) ("[T]he rule of reason requires the factfinder to decide whether under all the circumstances of the case the restrictive practice imposes an unreasonable restraint on competition."); *In re Wholesale Grocery Prods. Antitrust Litig.*, 752 F.3d 728, 733-34 (8th Cir. 2014) ("numerous factual questions" exist regarding reasonableness of restraint); *Perceptron, Inc. v. Sensor Adaptive Machs., Inc.*, 221 F.3d 913, 919 (6th Cir. 2000) (reasonableness a jury determination); Hovenkamp, Herbert J., *The Rule of Reason*, 70

Fla. L. Rev. 81, 91 (2018) ("Within the rule of reason analysis, the question of whether a restraint is 'reasonable' is ordinarily one of fact.").

D. Plaintiffs Allege Antitrust Injury.

Antitrust injury is "injury of the type the antitrust laws were intended to prevent and that flows from that which makes [the] defendants' acts unlawful." *West Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 101 (3d Cir. 2010). "[T]the existence of an 'antitrust injury' is not typically resolved through motions to dismiss." *Brader v. Allegheny Gen. Hosp.*, 64 F.3d 869, 876 (3d Cir. 1995). ABIM nonetheless argued below that antitrust injury is not sufficiently alleged. The district court did not address the issue. [17]

Antitrust injury is established when the "challenged conduct affected the prices, quantity or quality of goods or services." *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 641 (3d Cir. 1996). Plaintiffs allege ABIM forces internists to purchase MOC, charges inflated monopoly prices for MOC, thwarts competition in the tied product, constrains the supply of internists, and raises the cost of medical practice for

[17] ABIM challenged below only whether the correct "type" of injury is alleged, not whether the injury "flows" from the unlawful conduct. *See* Dkt. 22-2 at 23-26; Dkt. 29-1 at 16-19.

internists. (¶¶ 4, 20, 26, 30, 37, 42, 54, 55, 56, 59, 61, 64-65, 68-70, 71, 75, 83, 91, 95, 104). Plaintiffs also allege "there is no evidence of an actual causal relationship between MOC and any beneficial impact on physicians, patients, or the public." (¶¶ 42-43, 136).

These allegations support all three of the *Mathews* indicia: ABIM's conduct affects price (*e.g.*, ABIM charges monopoly prices for MOC); quantity (*e.g.*, ABIM thwarts competition in the tied product), and quality (*e.g.*, there is no relationship between MOC and any beneficial impact on physicians, patients, or the public). As this Court has recognized, "a purchaser in a market where competition has been wrongfully restrained has suffered an antitrust injury." *In re Warfarin Sodium Antitrust Litig.*, 391 F.3d 516, 531 (3d Cir. 2004). *See also Eastman Kodak*, 504 U.S. at 478 ("higher service prices and market foreclosure—is facially anticompetitive and exactly the harm that antitrust laws aim to prevent").

ABIM, however, ignored these allegations entirely below, instead focusing on the individual Plaintiffs' lost income and employment opportunities. These additional damages, however, do not eclipse the MOC fees ABIM forces internists to pay, nor do they minimize or

eliminate the effect of ABIM's unlawful conduct on price, quantity, and quality. When illegal tying injures competition, a plaintiff is injured and antitrust injury established even if the plaintiff does not purchase the tied product. *See, e.g., Wells Real Estate, Inc. v. Greater Lowell Bd. of Realtors,* 850 F.2d 803, 814 (1st Cir. 1988).

II. THE DISTRICT COURT ERRED BY DISMISSING THE MONOPOLIZATION CLAIMS.

A. Standard Of Review.

This Court's review of the dismissal of the monopolization claims under Section 2 is plenary. *See Broadcom Corp.*, 501 F.3d at 306.

B. Plaintiffs State Monopolization Claims.

Having improperly made the determination contrary to Plaintiffs' well-pled factual allegations, that as a matter of law there cannot be separate products and an illegal tie, the district court dismissed the monopolization claims finding "no anticompetitive conduct on the part of ABIM." A-36. As explained in detail above, however, Plaintiffs allege numerous facts supporting separate demand and distinct products, and hence an illegal tie under Section 1. *See* pp. 24-38, *supra*. Thus, there are ample facts pled supporting anticompetitive conduct for purposes of the monopolization claims.

In addition, the district court erred in assuming that its mistaken resolution of the tying claims under Section 1 dictated a similar outcome for the monopolization claims. "'When the defendant is a dominant firm' and meets 'a much stricter power requirement,' however, 'the special screening function' of the tying factors is 'largely unnecessary and the more general standards of § 2 become relevant' because 'the technical requirements … attach only to per se ties.'" *Viamedia*, 951 F.3d at 468 (quoting Areeda & Hovenkamp, ¶ 777, at 324). The Seventh Circuit upheld the monopolization claim in *Viamedia* and rejected the lower court's "great effort" to "parse whether Comcast's conduct satisfies some platonic ideal of tying conduct." 951 F.3d at 469.

Because ABIM is a monopolist, tying conduct short of a Section 1 violation can nonetheless constitute anticompetitive conduct under Section 2. *See* Areeda & Hovenkamp, ¶ 777, at 324. Bundling by a monopolist "may be unlawful even if the items in the bundled package would not constitute separate products … the question is whether viewing the monopolist's conduct as a whole, it has unreasonably maintained or enhanced its monopoly position." *Id*. *See also Multistate Legal Studies*, 63 F.3d at 1550-51 (give-away of tied product precluding

tying claim of separate products under Section 1 did not preclude finding that same conduct was anticompetitive under Section 2); *C.R. Bard, Inc. v. MC Systems, Inc.*, 157 F.3d 1340, 1381-83 (Fed. Cir. 1998) (product modification theory of liability upheld for Section 2 claim).

Plaintiffs also allege a range of other anticompetitive conduct by ABIM, including: leveraging its monopoly in certifications; forcing internists to buy MOC; thwarting competition; placing market participants on its board of directors; waging a campaign of deception about the benefits of MOC; constantly making burdensome changes to MOC; monopoly pricing; and rendering internists unable to assess lifetime costs of MOC. (¶¶ 4-6, 26-27, 31-34, 37, 42, 44, 49-51, 55, 57, 59-65, 67-68, 70-71, 73, 127-129, 133-135).

The district court summarily rejected most of these as facially invalid, again relying on its "finding" of a single product for purposes of the Section 1 claim. A-34. [18] Even assuming a single product for Section

[18] The district court did address two of Plaintiffs' allegations, that market participants (other internists) serve on the ABIM board of directors and ABIM's campaign of deception about the alleged benefits of MOC. A-34-37. It rejected the former invoking the baseless assumption that the ABIM directors could be burdened with "indiscriminate discovery requests left to the whim of Plaintiffs." A-36. Imagined discovery concerns, however, are best addressed under the

1 purposes, however, this conduct is sufficiently alleged as anticompetitive under Section 2. Plaintiffs allege many well-pled facts supporting ABIM's anticompetitive conduct, including not only tying but other anticompetitive acts as well, and dismissal of the monopolization claims should be reversed.

III. THE DISTRICT COURT ERRED BY DISMISSING PLAINTIFFS' RICO CLAIMS.

A. Standard Of Review.

This Court's review of the dismissal of the RICO claim is plenary. *See Broadcom Corp.*, 501 F.3d at 306.

B. Plaintiffs Allege Injury Proximately Caused By ABIM's RICO Violations.

The district court held Plaintiffs did not have standing because they failed adequately to allege that ABIM's RICO violations proximately caused their injuries: "ABIM's alleged fraudulent

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discovery rules and not by summarily dismissing claims. ABIM's fraudulent misrepresentations about MOC were excused because, according to the court, ABIM did not coerce hospital, insurers, and others. *Id*. But as explained immediately below in connection with Plaintiffs' RICO claim, this ignores Plaintiffs' allegations that ABIM's campaign of deception has been successful as hospitals, insurers, and others believe its fraudulent statements about MOC and as a result require internists to buy MOC.

statements are too attenuated to substantiate a claim." A-40. In reaching this conclusion, however, the court found facts inconsistent with Plaintiffs' allegations, ignored other well-pled allegations of fact, and misunderstood the RICO scheme alleged.

The RICO scheme here is simple and plausible. ABIM's first CPD product, its voluntary "Continuous Professional Development Program," failed due to lack of sales. (¶ 25). ABIM realized its new CPD product, MOC, could generate the fees desired by ABIM only if internists were forced to buy MOC to keep their certifications from being revoked. (¶¶ 4, 26-27, 44, 49, 61, 144, 148). Knowing MOC could not succeed on its own merits, ABIM waged a campaign, "to deceive the public, including but not limited to hospitals and related entities, insurance companies, medical corporations and other employers, and the media, that MOC, among other things, benefits physicians, patients and the public and constitutes self-regulation by internists." (¶¶ 6, 131; *see also* ¶¶ 42-43, 94, 133-135, 154, 166, 167, 168c, 168d).

The goal of ABIM's campaign of fraudulent misrepresentations is to convince hospitals, insurers, and others to require internists to buy MOC, "in order to obtain hospital consulting and admitting privileges,

reimbursement by insurance companies, employment by medical corporations and other employers, malpractice coverage, and other requirements of the practice of medicine." (¶¶ 6, 166). ABIM's campaign has been successful; hospitals, insurers, and others believe ABIM's fraudulent statements and require internists to buy MOC. (¶¶ 6, 37, 38, 39, 63, 131, 166).

Plaintiffs and other internists are injured by the RICO scheme. The goal of ABIM's campaign of deception is to drive sales of MOC and generate MOC fees from internists. (¶¶ 4, 44, 65, 163-164). ABIM's success is manifest: MOC has generated hundreds of millions of dollars in fees, with MOC revenue nearly tripling the last eleven years alone as ABIM repeatedly increased MOC fees. (¶¶ 30, 31-34, 65, 143-147). [19] The new MOC revenue is used to serve the economic interests of ABIM management, including overly generous compensation, ABIM's lavish

[19] The individual Plaintiffs suffered other injuries in addition to the payment of MOC fees. (¶¶ 76-80 (Dr. Kenney), 85-89 (Dr. Joshua), 93, 95-96, 100-101 (Dr. Manalo), 105, 108-109, 112 (Dr. Murray-Leisure)). The district court questioned some of these additional injuries but accepted the payment of MOC fees as cognizable RICO injuries. A-37-39.

pension plan, and purchase of a $2.3 million condominium used by ABIM management. (¶¶ 132, 148-153, 164, 167).

The district court rejected the RICO claims, finding first that Plaintiffs' understanding of MOC "is fundamentally flawed" because MOC is required to "maintain an ABIM certification" and ABIM "has the right to control who it is certifying and what standards and requirements are necessary." A-39. But as detailed above, MOC was created to generate revenue for ABIM and the court's unquestioned acceptance of ABIM's "standards" pretext for its unlawful conduct is both outside of and at odds with Plaintiffs' allegations. *See* pp. 4, 8, 27, 45, *supra*. That ABIM's "standards" pretext is specious is confirmed by the fact there is no evidence of a causal relationship between MOC and any benefit to physicians, patients, or the public. *See* pp. 9, 32, 45, *supra*.

More importantly, whether ABIM requires MOC has nothing to do with whether Plaintiffs suffer injury as a result of ABIM's RICO scheme. [20] ABIM still fraudulently misrepresents MOC to hospitals,

[20] Of course, ABIM's requirement that internists buy MOC or have their certifications revoked is itself part of its RICO scheme.

insurers, and others causing them to require internists to buy MOC. Nor do Plaintiffs contend ABIM should be prevented from determining its own standards, or be required to accept any other CPD product as a substitute for certifications or MOC.

The district court found, second, that "ABIM has not forced" internists to buy MOC. A-39. But as also detailed above, Plaintiffs sufficiently allege that internists are forced to purchase MOC or have their certifications revoked. *See* pp. 5-7, 9, 38-39 *supra*. The economic reality is that certifications are required to practice medicine successfully.

The court also attempted to shift responsibility from ABIM, asserting certain injuries of individual Plaintiffs (loss of privileges and employment) were the result of actions by hospitals and employers. A-39. This ignores, however, the hundreds of millions of dollars in MOC fees paid by internists, the principal RICO injury alleged. (¶¶ 163-164). These fees are required by ABIM, not by hospitals and employers. The district court's focus on these third parties fails because it misapprehends the RICO scheme alleged, that internists are the target

of ABIM's fraud and that Plaintiffs' injuries (payment of MOC fees) are the direct result of that fraud.

The district court relied on *Anza v. Ideal Steel Supply Corp.*, 547 U.S. 451, 460 (2006), but misapplied *Anza* to the facts alleged here. A-39-40. In *Anza*, the Supreme Court held a RICO claim could not proceed because the connection between the fraud alleged and the harm suffered was too attenuated. Anza, who owned National Steel Supply, had defrauded the State of New York by not paying state sales tax on cash sales, which allegedly allowed National Steel to charge lower prices. *Id.* at 454. Ideal Steel, a competitor, brought a RICO claim based on predicate acts of mail and wire fraud, alleging it was harmed by loss of sales to National Steel due to its fraud.

The Supreme Court concluded the RICO claim could not proceed because the direct target of the fraud was not Ideal Steel, but New York. *Id.* at 458-59. In other words, Ideal Steel's injuries were indirect and only derivative of National Steel's fraud. National Steel's price reductions could also be explained by factors other than National Steel not paying sales tax. *Id.* at 459. "The requirement of a direct causal connection is especially warranted where the immediate victims of an

alleged RICO violation [New York] can be expected to vindicate the laws by pursuing their own claims." *Id.* at 460.

Here, the targets and "immediate victims" of ABIM's RICO scheme are Plaintiffs and other internists. This lawsuit is likewise brought to "vindicate" internists and to pursue their "own claims." There is a "direct causal connection" between internists, the targets of ABIM's RICO scheme, and the MOC fees ABIM forces them to pay. And unlike New York in *Anza*, hospitals, insurers, and others are not injured by ABIM's fraud.

The RICO scheme alleged by Plaintiffs is much more analogous to *In re Avandia Mktg.*, 804 F.3d 633, 643-44 (3d Cir. 2015), in which this Court distinguished *Anza*. In *Avandia*, plaintiffs were third-party health insurance payers who alleged GlaxoSmithKline LLC ("GSK") concealed the risks of its drug Avandia by manipulating data and scientific literature to increase sales. *Id.* at 636. GSK did so "with a marketing campaign designed to sway doctors and consumer confidence," including advertisements and "the release of promotional materials to prescribing physicians." *Id.* at 635. GSK moved to dismiss the RICO claim arguing that the doctors who actually prescribed the

drug broke the causal chain between GSK and the third-party payers because the doctors relied on GSK's misrepresentations. *Id.* at 644-645.

This Court affirmed the denial of GSK's motion to dismiss, explaining that the presence of intermediaries did not destroy proximate cause because the third-party payers who paid for the drug were the targets and "'primary and intended victims of the scheme to defraud.'" *Id.* at 645, *quoting Bridge v. Phoenix Bond & Indemnity, Co.*, 553 U.S. 639, 650 (2008). The Court found that, unlike *Anza*, the third-party payers had alleged "a sufficiently direct relationship between the defendant's wrongful conduct and the plaintiff's injury." *Avandia,* 804 F.3d at 643.

This Court also found plaintiff had standing to pursue a RICO claim in *Brokerage Concepts*, 140 F.3d at 521. There, plaintiff BCI, a third-party administrator ("TPA"), alleged defendant United Healthcare had forced a drug store chain ("Gary's") to use United Healthcare's TPA rather than BCI through a series of acts of extortion and fraud directed at Gary's. [21] Proximate cause existed because, "BCI's TPA relationship

[21] Judgment for plaintiff on the RICO claims was ultimately reversed because of failure to prove the predicate acts. *Id.* at 529.

with Gary's was a direct target of the alleged scheme—indeed, interference with that relationship may well be deemed the linchpin of the scheme's success." *Id.* So too here, internists are the "direct target of the alleged scheme."

"When a court evaluates a RICO claim for proximate causation, the central question it must ask is whether the alleged violation led directly to the plaintiff's injuries." *Anza*, 547 U.S. at 461. Here, ABIM's fraudulent scheme led directly to Plaintiffs' and other internists' payment of MOC fees. History shows ABIM cannot generate fees if internists are free to refuse to buy MOC without losing hospital consulting and admitting privileges, reimbursement by insurers, employment by medical corporations and other employers, malpractice coverage, and other requirements of the practice of medicine. Internists are the targets of ABIM's RICO scheme because they pay MOC fees; hospitals, insurers, and others do not.

Furthermore, the harm here is not separate from the fraud, s*ee Devon Drive Lionville, LP v. Parke Bancorp, Inc.*, 791 Fed. App'x 301, 307 (3d Cir. 2019), because Plaintiffs' injuries are not derivative of any other injury. Plaintiffs and other internists are the only persons harmed

by ABIM's fraud. The hospitals, insurers, and others to whom the fraudulent representations were directed suffer no harm and have no reason to pursue claims against ABIM. [22]

Indeed, Plaintiffs and other internists are the only persons injured by ABIM's fraudulent scheme, just as the third-party payers in *Avandia* were the only ones injured by GSK's fraudulent scheme. *See* 804 F.3d at 645. Because Plaintiffs' RICO allegations satisfy the proximate cause requirements of *Anza* and this Circuit, the district court erred in concluding Plaintiffs did not have standing.

IV. THE DISTRICT COURT ERRED BY DISMISSING THE UNJUST ENRICHMENT CLAIM.

A. Standard Of Review.

This Court's review of the dismissal of the unjust enrichment claim is plenary. *See Broadcom Corp.*, 501 F.3d at 306.

B. Plaintiffs State A Claim For Unjust Enrichment.

The elements of a claim for unjust enrichment in Pennsylvania are: "(1) a benefit was conferred on the defendant; (2) the defendant

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[22] The district court was incorrect when it concluded, "The Amended Complaint contains no allegations that ABIM had any control over internist-requirements at the Plaintiffs' employers." A-40. Plaintiffs allege hospitals and others require internists to buy MOC because they believe ABIM's misrepresentations. (¶¶ 6, 38, 39, 63, 131, 166).

retained that benefit; and (3) it would be inequitable for the defendant to retain the benefit without paying full value for it." *Payne v. Lampe*, 665 F.3d 506, 520 (3rd Cir. 2011). "[T]here is not a rigid formula that can be applied in a determination of whether there has been unjust enrichment as that determination depends on the unique factual circumstances of each case." *Id.* (internal quotation omitted).

The district court held Plaintiffs' allegations satisfied the first two elements but failed to sufficiently plead the third, concluding "it is not inequitable for ABIM to keep the benefit because it did not 'force' Plaintiffs to purchase MOC." A-41. Again, however, the court cited nothing in the Complaint to support its finding there was no forcing. To the contrary, Plaintiffs sufficiently allege that internists are, indeed, forced to purchase MOC. *See* pp. 5-7, 9, 38-39, *supra.*

The economic reality is that internists whose certifications are revoked by ABIM because they do not buy MOC are no longer eligible for admitting and other privileges, employment, insurance coverage, and other requirements for the successful practice of medicine. (¶¶ 37-38, 39, 40, 77-78, 87, 88, 95-96, 98, 109, 155, 166). Internists prefer to buy products from others to keep current rather than being forced to

buy MOC from ABIM. (¶¶ 55, 66). They do not have that choice, however, because if they do not buy MOC, ABIM revokes their certifications. (¶¶ 26, 44, 49, 61). This inequitable conduct forces internists to buy a product they do not want, one they chose not to buy when ABIM originally sold it as a voluntary CPD product. (¶¶ 25-26).

The district court ignored Plaintiffs' well-pled allegations of forcing. It also disregarded Plaintiffs' allegations that ABIM was unjustly enriched because it leveraged its monopoly power in certifications to charge inflated monopoly prices for MOC. (¶¶ 4, 64, 68). These allegations sufficiently plead that ABIM's retention of the hundreds of millions of dollars in MOC fees "would be inequitable." *Payne*, 665 F.3d at 520. The dismissal of Plaintiffs' unjust enrichment claim should be reversed.

CONCLUSION

For the foregoing reasons, Plaintiffs-Appellants respectfully ask this Court to reverse the dismissal of their Amended Class Action Complaint.

Dated: May 4, 2020

Respectfully submitted,

/s/ C. Philip Curley
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CERTIFICATION

I, Cynthia H. Hyndman, one of the counsel for Plaintiffs-Appellants, and a member of the bar of this Court, hereby certify as follows:

(1) Pursuant to Circuit Rule 28.3(d), at least one of the attorneys whose name appears on this Brief is a member of the bar of this Court.

(2) 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 font on Microsoft Office Word 2016 and has 12,993 words according to the Microsoft Word count.

(3) Pursuant to Circuit Rule 31.1(c), the electronic version of this brief and the hard copies to be filed with the Court are identical.

(4) Pursuant to Circuit Rule 31.1(c), a virus check was performed on this brief using Trend Micro agent version 6.7.1293/14.2.1161 and no virus was detected.

Dated: May 4, 2020

/s/ Cynthia H. Hyndman

No. 20-1007

IN THE UNITED STATES COURT OF APPEALS
FOR THE THIRD CIRCUIT

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHLEEN MURRAY-LEISURE,

Plaintiffs-Appellants,

v.

AMERICAN BOARD OF INTERNAL MEDICINE,

Defendant-Appellee.

Appeal from the United States District Court
for the Eastern District of Pennsylvania
Case No. 2:18-cv-5260-WB
The Honorable Judge Wendy Beetlestone

APPENDIX TO BRIEF OF PLAINTIFFS-APPELLANTS VOL. I (A-1 TO A-41)

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHERINE MURRAY LEISURE,	)	
Plaintiffs,	)	
v.	)	**No. 2:18-cv-05260-WB**
AMERICAN BOARD OF INTERNAL MEDICINE,	)	
Defendant.	)	

NOTICE OF APPEAL

Notice is hereby given that Plaintiffs Gerard Kenney, Alexa Joshua, Glen Dela Cruz Manalo, and Katherine Murray Leisure, appeal to the United States Court of Appeals for the Third Circuit from the Court's Memorandum Opinion dated September 26, 2019, granting Defendant's Motion to Dismiss Plaintiffs' Amended Complaint and from the entry of final judgment on December 6, 2019.

Date: December 30, 2019

Respectfully submitted,

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IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHERINE MURRAY LEISURE,	)	
Plaintiffs,	)	
v.	)	**No. 2:18-cv-05260-WB**
AMERICAN BOARD OF INTERNAL MEDICINE,	)	
Defendant.	)	

CERTIFICATE OF SERVICE

I, Cynthia H. Hyndman, an attorney, hereby certify that I caused a copy of the foregoing **Notice of Appeal** to be served on the following persons by electronic transmission via CM/ECF on December 30, 2019:

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WB

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UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF PENNSYLVANIA

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHERINE MURRAY LEISURE, Plaintiffs, v. AMERICAN BOARD OF INTERNAL MEDICINE, Defendant.	Civil Action No. 2:18-CV-5260-WB

FILED
DEC 06 2019
KATE BARKMAN, Clerk
By Dep. Clerk

JOINT STIPULATION FOR ENTRY OF FINAL JUDGMENT AND ORDER

Plaintiffs and defendant American Board of Internal Medicine ("ABIM"), by and through their respective counsel, hereby stipulate as follows:

WHEREAS, the Complaint in this action was filed on December 6, 2018;

WHEREAS, Plaintiffs filed an Amended Complaint (Docket No. 19) on January 23, 2019;

WHEREAS, ABIM filed a motion to dismiss Plaintiffs' Amended Complaint (Docket No. 22) on March 18, 2019;

WHEREAS, Plaintiffs filed their response in opposition (Docket No. 28) on April 30, 2019;

WHEREAS, ABIM filed its reply in further support of its motion to dismiss (Docket No. 31) on May 20, 2019;

WHEREAS, the Court entered its Memorandum Opinion and Order (Docket Nos. 34-35) on September 26, 2019, dismissing Counts I and IV of Plaintiff's Amended Complaint with

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prejudice, and Counts II and III without prejudice and with leave to amend within fourteen days therefrom;

WHEREAS, Plaintiffs did not amend Counts II and III;

IT IS HEREBY STIPULATED AND AGREED by the parties, subject to the approval of the Court, that it is appropriate for the Court to enter a final judgment against Plaintiffs and in favor of ABIM on all Counts consistent with Fed. R. Civ. P. 58(d).

This Stipulation is without prejudice to (i) Plaintiffs' position that they reserve the right to appeal from that judgment consistent with the Federal Rules of Civil Procedure and the Federal Rules of Appellate Procedure; and (ii) ABIM's position that it reserves the right to object to or oppose any such appeal.

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Dated: December 3, 2019

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SO ORDERED this 5th day of December, 2019.

The Honorable Wendy Beetlestone, U.S.D.J.

IN THE UNITED STATES DISTRICT COURT
FOR THE EASTERN DISTRICT OF PENNSYLVANIA

GERARD KENNEY, ALEXA JOSHUA, GLEN DELA CRUZ MANALO, and KATHERINE MURRAY LEISURE,	:	CIVIL ACTION
Plaintiffs,	:	No. 18-5260
v.	:	
AMERICAN BOARD OF INTERNAL MEDICINE,	:	
Defendant.	:	

MEMORANDUM

ROBERT F. KELLY, Sr. J. **SEPTEMBER 26, 2019**

Plaintiffs Gerard Kenney ("Kenney"), Alexa Joshua ("Joshua"), Glen Dela Cruz Manalo ("Manalo"), and Katherine Murray Leisure ("Murray") (collectively, "Plaintiffs") bring this action against Defendant American Board of Internal Medicine ("ABIM") alleging violations of Sections 1 and 2 of the Sherman Act, 15 U.S.C. §§ 1–2, the Racketeer Influenced and Corrupt Organizations Act ("RICO"), 18 U.S.C. § 1962(c), and a claim of unjust enrichment.

ABIM moves to dismiss the Amended Complaint for failure to state a claim under Federal Rule of Civil Procedure 12(b)(6). Plaintiffs filed a Memorandum of Law in Opposition to ABIM's Motion and ABIM filed a Reply in Support.

For the reasons noted below, ABIM's Motion to Dismiss the Amended Complaint is granted.

I. BACKGROUND[1]

A. Initial Certification and Maintenance of Certification Market

Licenses to practice medicine in the United States are granted by the medical boards of individual states. (Am. Compl. ¶ 18.) To obtain a license, a physician is required to, among other things, have a medical degree and to pass the United States Medical Licensing Examination ("USMLE"), a three-step examination for medical licensure sponsored by the Federation of State Medical Boards ("FSMB") and the National Board of Medical Examiners ("NBME"). (*Id.*) According to the USMLE website, the examination "assesses a physician's ability to apply knowledge, concepts, and principles, and to demonstrate fundamental patient-centered skills, that are important in health and disease and that constitute the basis of safe and effective patient care." (*Id.* ¶ 19.)

Most states require physicians to periodically complete continuing medical education courses ("CME") to remain licensed. (*Id.* ¶ 20.) According to the website of the Accreditation Council for Continuing Medical Education ("ACCME"), which accredits organizations that offer continuous medical education, CME "consists of educational activities which serve to maintain, develop, or increase the knowledge, skills and professional performance and relationships that a physician uses to provide services for patients, the public, or the profession." (*Id.*)

ABIM offers its own certification. Its certification "demonstrates that physicians have completed internal medicine and subspecialty training and have met rigorous standards through intensive study, self-assessment and evaluation" and "encompasses the six general competencies established by the Accreditation Council for Graduate Medical Education." (*Id.* ¶ 21.)

[1] We take the facts alleged in the Amended Complaint as true, as we must when deciding a motion under Federal Rule of Civil Procedure 12(b)(6). *See Connelly v. Lane Constr. Corp.*, 809 F.3d 780, 786 (3d Cir. 2016) (citation omitted).

Approximately 80% of internists, and almost all practicing internists, purchase initial ABIM certifications. (*Id.*) Those who do not include researchers, teachers, academics, and others who may not regularly treat patients. (*Id.*)

To obtain initial ABIM board certification, a physician must, among other things, pass an ABIM-administered examination. (*Id.* ¶ 22.) ABIM first began selling initial certifications in 1936. (*Id.*) No state requires an initial ABIM certification for an internist to obtain a license to practice medicine. (*Id.*)

At the start, ABIM certifications were lifelong and no subsequent examinations or other requirements were imposed by ABIM on internists. (*Id.* ¶ 24.) However, in or about 1974, ABIM devised a voluntary Continuous Professional Development Program ("CPD") for ABIM-certified internists as a complement to its initial board certification. (*Id.* ¶ 25.) The first CPD examination was administered by ABIM in 1974. (*Id.*) Only 3,355 internists took the voluntary examination. (*Id.*) In 1977, just 2,240 internists took the second voluntary CPD examination. (*Id.*) Only 1,947 internists took the third voluntary examination in 1980. (*Id.*)

Faced with declining participation, and the resulting drop in enrollment fees paid by internists for the voluntary examinations, ABIM announced that it would no longer issue lifelong certifications and would, instead, require internists to take subsequent must-pass examinations. (*Id.* ¶ 26.) By no later than 1990, ABIM issued only time-limited initial certifications and forced internists to take new, must-pass examinations every ten years or lose their ABIM certification. (*Id.*) However, physicians that purchased ABIM initial certifications prior to 1990 were "grandfathered" in and exempt from purchasing these Maintenance of Certification products ("MOC"). (*Id.* ¶ 27.) ABIM still considers these pre-1990 certified internists "certified." (*Id.*)

In January 2006, ABIM imposed changes to MOC. (*Id.* ¶ 31.) Internists were now also required to accumulate 100 "MOC points" every ten years by completing medical knowledge and practice performance processes, which resulted in substantial additional MOC fees for ABIM. (*Id.*) No other organization or entity offered competing maintenance of certification for internists at this time. (*Id.*) ABIM continued to exempt "grandfathered" internists from the requirement to purchase MOC and continued to report them as "Certified." (*Id.*) In 2014, in addition to the must-pass examination every ten years, ABIM-certified internists were required to complete an "MOC activity" every two years and a patient safety and patient survey module every five years. (*Id.* ¶ 32.) They were also required to accumulate 100 MOC points every five years, instead of the original ten. (*Id.*)

These changes resulted in substantial additional indirect costs to internists in terms of time taken away from their practice, patients, and families. (*Id.* ¶ 33.) ABIM-certified internists were now also required to "enroll" in MOC. (*Id.*) If they did not, ABIM reported them on its website as "Not Meeting MOC Requirements." (*Id.*) No other organization or entity offered competing MOC for internists at this time. (*Id.*) ABIM continued to exempt "grandfathered" internists from the requirement to purchase MOC and continued to report them as "Certified." (*Id.*)

In 2018, ABIM changed MOC once again. (*Id.* ¶ 34.) Internists are now required to pay an annual program fee to participate in MOC ($160 in 2019 if paid in the year due), in addition to paying an "assessment fee" for MOC examinations. (*Id.*) Those purchasing MOC for internal medicine now have the option of taking a "Knowledge Check-In" test every two years or the single "traditional" must-pass examination every ten years, both of which are now "open-book."

(*Id.*) ABIM is phasing in the "Knowledge Check-In" option for subspecialties over the next three years. (*Id.*)

Currently, internists who have not purchased MOC from ABIM are reported on ABIM's website as "Not Certified," even though they purchased an initial ABIM certification. (*Id.* ¶ 35.) ABIM, however, reports "grandfathered" internists as "Certified" even though they do not participate in MOC solely because they purchased an initial ABIM certification before 1990. (*Id.*) Allegedly, "grandfathered" internists who have voluntarily taken and failed MOC examinations are still reported by ABIM as "Certified." (*Id.*)

One analysis projected that complying with MOC costs internists an average of $23,607 in money and time over a ten year period, with costs up to $40,495 for some specialists, and that "[t]he 2015 MOC is projected to cost $5.7 billion [internal reference omitted] over the coming decade" from 2015 to 2024, including time costs resulting from 32.7 million physician hours. (*Id.* ¶ 36.)

Hospital care is the largest component of health care spending in the United States, accounting for more than $1 trillion a year. (*Id.* ¶ 38.) The second largest component is physician and clinical services, many of which are now provided by hospitals. (*Id.*) Allegedly, with the assistance and encouragement of ABIM, and/or persons affiliated with ABIM, many hospitals have adopted bylaws mandating that physicians purchase MOC. (*Id.*) This is magnified in hospital markets that are highly concentrated, *i.e.*, those markets with fewer and typically larger hospitals. (*Id.*) Approximately 77% of Americans living in metropolitan areas are in hospital markets considered highly concentrated. (*Id.*)

MOC has become increasingly mandatory for internists across the country. (*Id.* ¶ 37.) Plaintiffs and other internists are required by many hospitals and related entities, insurance

companies, medical corporations, and other employers to be ABIM-certified to obtain hospital consulting and admitting privileges, reimbursement by insurance companies, employment by medical corporations and other employers, malpractice coverage, and other requirements of the practice of medicine. (*Id.*) To create incentive for internists to purchase MOC, ABIM also obtained, as part of the Affordable Care Act, a temporary 0.5% Medicare payment incentive for doctors participating in MOC. (*Id.*) As a result of these and other circumstances described herein, ABIM-certified internists are forced to purchase MOC or suffer substantial economic consequences. (*Id.*)

As an example, many Blue Cross Blue Shield companies ("BCBS"), again with the alleged assistance and encouragement of ABIM, and/or persons affiliated with ABIM, require physicians to participate in MOC to receive a panel of patients in their plans or be included in their networks. (*Id.* ¶ 39.) Patients of internists that do not purchase MOC have been told that their physicians are no longer preferred providers and that they should look for another primary care doctor. (*Id.*) In addition, patients whose internists have been denied coverage by BCBS because they have not complied with ABIM's MOC requirements, are typically required to pay a higher "out of network" coinsurance rate (for example, 10% in network versus 30% out of network) to their financial detriment. (*Id.*) Nearly one in three Americans have BCBS coverage, and nationwide 96% of hospitals and 92% of physicians are in-network with BCBS. (*Id.*)

No state requires ABIM certification for an internist to be licensed. (*Id.* ¶ 41.) Almost thirty years after ABIM's action to require internists to purchase MOC, no evidence-based relationship has been established between MOC and any beneficial impact on physicians, patients, or the public. (*Id.* ¶ 42.) This is in marked contrast with the evidence-based medicine ("EBM") practiced today. (*Id.*) EBM optimizes medical decision-making by emphasizing the

use of evidence from well-designed and well-conducted research. (*Id.*) That there is no evidence of an actual causal relationship between MOC and any beneficial impact on physicians, patients, or the public is supported by the facts that: (1) ABIM does not require those it has "grandfathered" to comply with MOC, and (2) according to its website, even ABIM's own recently-funded research only "suggest[s] that MOC is a marker of care quality . . . ." (*Id.* ¶ 43.) Indeed, at least two ABMS member websites currently include the following statement: "Many qualities are necessary to be a competent physician, and many of these qualities cannot be measured. Thus, board certification is not a warranty that a physician is competent." (*Id.*)

The American Medical Association ("AMA") has adopted "AMA Policy H-275.924, Principles on Maintenance of Certification (MOC)," which states, among other things, that "MOC should be based on evidence," "should not be a mandated requirement for licensure, credentialing, reimbursement, network participation or employment," should be relevant to clinical practice," "not present barriers to patient care," and "should include cost effectiveness with full financial transparency, respect for physician's time and their patient care commitments, alignment of MOC requirements with other regulator and payer requirements, and adherence to an evidence basis for both MOC content and processes." (*Id.* ¶ 46.)

Plaintiffs contend that the product markets relevant to this action are the market for initial board certification of internists and the market for maintenance of certification of internists, while the relevant geographic market is the United States. (*Id.* ¶¶ 47–48.) ABIM's website makes clear that, except for those "grandfathered" by ABIM, certifications "must be maintained through ABIM's MOC programs." (*Id.* ¶ 44.) By requiring internists to purchase MOC to remain certified, ABIM supposedly created a wholly new and artificial market for MOC that has generated substantial fees for ABIM. (*Id.*)

According to ABIM's 2016 Form 990 filed with the Internal Revenue Service, MOC "means something different from initial certification" and "speaks to the question of whether or not an internist is staying current with knowledge and practice in his/her discipline" and is "anchored in whether a physician is meeting a performance standard." (*Id.* ¶ 53.) Thus, MOC serves substantially the same function as CME. (*Id.* ¶ 54.) Indeed, MOC points are granted for some contracted external CME activities from subspecialty societies. (*Id.*) Likewise, completion of some MOC education modules might count towards a physician's state licensure CME requirement. (*Id.*) Importantly, however, MOC differs from CME because if physicians do not see value in particular CME courses they are free to purchase other CME offerings; there is no such meaningful option regarding MOC. (*Id.*)

Beginning in or about 1990, all internists purchasing initial ABIM certifications have been required to purchase MOC or have their certification terminated by ABIM. (*Id.* ¶ 49.) Initial ABIM certification is required by ABIM to purchase MOC. (*Id.*) Throughout the relevant period, ABIM has controlled the market for initial certification of internists in the United States. (*Id.* ¶ 50.) There are high barriers to entry in the market for initial certification, including technical, economic, and organizational barriers, as demonstrated by the fact that no other organization or entity has ever offered meaningful competing initial certifications for internists. (*Id.*) According to Plaintiffs, ABIM has the market power in the market of initial certification of internists and has used that power to unlawfully tie its MOC products. (*Id.* ¶¶ 51–52.)

However, internists have a desire to obtain MOC from providers other than ABIM, but have been almost entirely unsuccessful as a result of ABIM's alleged illegal tying and unlawful and exclusionary use of its monopoly power. (*Id.* ¶ 55.) The National Board of Physicians and Surgeons ("NBPAS") was established in or about January 2015 to provide a competing MOC

product to physicians. (*Id.* ¶ 56.) Its product extends to physicians practicing in all twenty-four ABMS specialties, including internal medicine. (*Id.*) NBPAS does not offer initial certifications to internists or any other physicians, but only MOC. (*Id.*)

To obtain MOC from NBPAS, a physician must, among other things, have at one time held a certification from an ABMS member board, hold a valid state license to practice medicine, and complete at least fifty hours of accredited CME within the past twenty-four months (or one hundred hours if an ABIM certification has lapsed). (*Id.* ¶ 57.) NBPAS fees are vastly lower than those charged by ABIM for MOC, and NBPAS MOC requires vastly less physician time. (*Id.*) In 2017, NBPAS fees were less than 15% of the fees assessed by ABIM for MOC and required much less administrative time for registration. (*Id.*)

According to Plaintiffs, the fact that NBPAS offers MOC, but not initial certification further establishes that the two markets are separate. (*Id.* ¶ 58.) NBPAS has had very limited success. (*Id.* ¶ 59.) In 2016, there were over 10,000 hospitals in the United States, including both those registered with the American Hospital Association ("AHA") and community hospitals, however, as of September 2, 2018, only 91 hospitals, less than one percent, accepted NBPAS maintenance of certification, and not a single insurance company is known to accept NBPAS. (*Id.*) In addition, ABIM does not recognize NBPAS maintenance of certification. (*Id.*) Upon information and belief, organizations in addition to NBPAS, have considered entering, or sought to enter, the market for MOC services. but have been unsuccessful because of the monopoly power and unlawful exclusionary conduct of ABIM. (*Id.* ¶ 60.)

Allegedly, ABIM is illegally tying its initial certification to MOC. (*Id.* ¶ 61.) As a direct and proximate result, Plaintiffs allege that they and other internists have been forced to purchase MOC from ABIM since at least 1990 or lose their ABIM certifications. (*Id.* ¶¶ 61, 65.) ABIM

also allegedly created and maintained unlawful monopoly power for MOC by requiring internists to purchase MOC or lose their ABIM certification. (*Id.* ¶ 62.) According to Plaintiffs, ABIM has induced hospitals and related entities, insurance companies, medical corporations, and other employers to require internists to be ABIM-certified to obtain hospital consulting and admitting privileges, reimbursement by insurance companies, employment by medical corporations and other employers, malpractice coverage, and other requirements of the practice of medicine. (*Id.* ¶ 63.)

ABIM is governed by a board of directors that includes active participants in the market for internists' services and related markets. (*Id.* ¶ 71.) Plaintiffs allege that ABIM's restraint on competition in the market for internists' services, demonstrated conflicts of interests, and private anticompetitive motives force internists, other than those "grandfathered" by ABIM, to purchase MOC or lose their ABIM certification. (*Id.*)

B. Background of Named Plaintiffs

1. Gerard Francis Kenney, MD

Kenney entered private practice in 1995 as a partner in Digestive Health Specialists, Inc. ("Digestive Health") in Seneca, Pennsylvania, and has been practicing gastroenterology for almost 25 years. (*Id.* ¶ 74.) Gastroenterologists diagnose and treat digestive disorders, such as stomach pain, ulcers, reflux, and Crohn's disease. (*Id.*) He served as President of the Venango County Medical Society and Councilor (Region I) of the Pennsylvania Society of Gastroenterology. (*Id.*) Kenney is a member of, among other professional associations, the American Gastroenterological Association and the American College of Gastroenterology. (*Id.*)

Kenney obtained an initial board certification in internal medicine from ABIM in 1993, and a gastroenterology subspecialty certification in 1995. (*Id.* ¶ 75.) ABIM did not

"grandfather" these initial certifications because they were purchased after 1990. (*Id.*) Kenney later passed MOC examination in gastroenterology in 2007. (*Id.*) Allegedly, a proctor who administered the examination referred to MOC as a "money-making operation." (*Id.*)

In November 2017, Kenney accepted an offer of employment from Mount Nittany Physicians Group ("MNPG") that would have doubled his income. (*Id.* ¶ 76.) MNPG is a multi-specialty group practice owned by Mount Nittany Medical Center in State College, Pennsylvania. (*Id.*) In order to assure an orderly transition, Kenney told his partner that he planned to leave Digestive Health at year-end 2017 and would begin employment with MNPG in early 2018. (*Id.*) He also told his staff of thirty of his plans, in order to give them time to find alternative employment. (*Id.*)

Kenney was later told that, in order to be employed by MNPG, he would be required to maintain his ABIM certification in gastroenterology, which was scheduled to be terminated by ABIM effective December 31, 2017. (*Id.* ¶ 77.) By this time, Kenney had already decided not to take the MOC examination again, though he had already paid his MOC annual fees through December 31, 2018. (*Id.*) In addition, it was impossible for Kenney to meet MNPG's requirement because ABIM was not offering the MOC gastroenterology examination again in 2017. (*Id.*) MNPG then revised its offer, extending Kenney's start date to June 20, 2018, but only contingent upon his passing the next MOC gastroenterology examination, which was scheduled for April 2018. (*Id.* ¶ 78.) It was understood that MNPG's offer would be rescinded if Kenney failed the April examination. (*Id.*)

Kenney had already given his notice of departure to Digestive Health; therefore, he would effectively be unemployed at the end of 2017. (*Id.* ¶ 79.) Thus, Kenney, who was unwilling to face at least six months without any income, which would become longer if he did

not pass the MOC examination, decided to reject the revised offer of employment from MNPG. (*Id.*)

ABIM currently reports Kenney as "Not Certified" on its website even though he obtained initial certifications in internal medicine and gastroenterology. (*Id.* ¶ 80.) Plaintiffs contend that this is misleading because it makes it appear as if the initial certifications were revoked due to failure to pass a MOC examination, misconduct, or some similar reason rather than having been terminated by ABIM simply because they had lapsed. (*Id.*) This is reinforced by ABIM's failure to report Kenney's gastroenterology MOC certification in 2007 on its website. (*Id.*) Because of this presentation by ABIM, Kenney appears less qualified to patients, hospitals, insurance companies, medical corporations, other employers, and other. (*Id.*) Kenney believes this method of reporting by ABIM on its website pressures doctors into purchasing MOC. (*Id.*)

2. Alexa Joshua, MD

Joshua has provided care for patients in hospital and medical office settings, as well as through visits with home-bound patients. (*Id.* ¶ 81.) She has served patients of ethnically and culturally diverse backgrounds, caring for the insured, underinsured, and uninsured. (*Id.*) In 2013, Joshua was selected for advancement to Fellowship by the American College of Physicians ("ACP"), described on the ACP website as "a mark of distinction representing the pinnacle of integrity, professionalism, and scholarship for doctors pursuing careers in internal medicine," but ultimately declined the invitation for cost reasons. (*Id.* ¶ 81.)

In 1989, Joshua began working as an internist affiliated with Henry Ford Hospital, providing inpatient care as an employee of Metro-Medical Group, a subsidiary of Health Alliance Plan. (*Id.* ¶ 82.) Joshua held consulting and admitting privileges through her affiliation

with Henry Ford Hospital. (*Id.*) In 2000, Joshua founded Amethyst Medical Offices, PLC, d/b/a Docrxtor Patience Medical Clinics, PLC, a private internal medicine practice. (*Id.*) Joshua obtained an initial board certification in internal medicine from ABIM in 2003. (*Id.* ¶ 83.) ABIM did not "grandfather" her initial certification because it was purchased after 1990. (*Id.*)

Also in 2003, Joshua affiliated with Detroit Medical Center ("DMC"), the leading Detroit hospital and largest health care provider in Southeast Michigan. (*Id.* ¶ 84.) Joshua held consulting and admitting privileges at five area hospitals through her affiliation with DMC, allowing her to admit patients and to consult with other doctors regarding their admitted patients. (*Id.*)

In 2009, six years after she began her affiliation with DMC, Joshua and the rest of the DMC medical staff received a written notice titled, "IMPORTANT CREDENTIALING INFORMATION" requiring that effective July 1, 2009, "Board certification must be maintained in those specialty boards that are time-limited." (*Id.* ¶ 85.) Joshua did not pass the required MOC examination in 2014, after which ABIM terminated her certification in internal medicine. (*Id.*) However, she continued to participate in MOC through December 31, 2017. (*Id.*)

After Joshua's certification was terminated by ABIM, her DMC patients were treated by another doctor, who, because he had never been certified by ABIM, was not required by DMC to participate in MOC. (*Id.* ¶ 86.) On June 1, 2016, Joshua was told that BCBS would no longer cover her because it required certification through ABIM. (*Id.* ¶ 87.) Joshua appealed the decision, telling BCBS, among other things, that she had been certified by NBPAS in 2015. (*Id.*) BCBS rejected her appeal. (*Id.*)

Joshua's DMC consulting and admitting privileges expired on December 31, 2017.

(*Id.* ¶ 88.) Because she had not complied with DMC's certification requirement, she was not allowed to renew those privileges. (*Id.*) As a result, Joshua was no longer permitted to provide inpatient care. (*Id.*) Joshua was restricted to "Membership Only" status, allowing her to provide only outpatient care to DMC patients. (*Id.*)

ABIM currently reports Joshua on its website as "Not Certified" even though she obtained an initial certification in internal medicine. (*Id.* ¶ 89.) The ABIM website also advises that if a doctor is not listed as certified, "they may be certified by another board of the American Board of Medical Specialties," but does not refer to NBPAS, from which Joshua holds a certification, as an alternative certifying board. (*Id.*)

3. Glen Dela Cruz Manalo, MD

Manalo held teaching appointments at James H. Quillen College of Medicine as a clinical instructor from 1997 to 2000, and at Vanderbilt University School of Medicine as an associate professor of medicine from 2002 to 2007. (*Id.* ¶ 90.) Manalo was selected as a top gastroenterologist in Billings, Montana, by the International Association of Healthcare Professionals for 2011. (*Id.*) Manalo obtained an initial board certification in internal medicine from ABIM in 1997, and a gastroenterology subspecialty certification in 2000. (*Id.* ¶ 91.) ABIM did not "grandfather" these initial certifications because they were purchased after 1990. (*Id.*)

Manalo served as staff gastroenterologist with Tennessee Valley Health Care Systems, a United States Department of Veterans Affairs medical center, from September 2002 to September 2007. (*Id.* ¶ 92.) In October 2007, Manalo took a position at St. Vincent Healthcare ("St. Vincent") in Billings, Montana, at a base salary of $400,000, capped at $800,000 annually, and also received a lump sum recruitment incentive of $50,000. (*Id.*) He replaced a doctor who

had recently retired and who had never been certified by ABIM in internal medicine or gastroenterology. (*Id.*)

Manalo's ABIM certification in internal medicine was terminated in 2007 after he decided not to purchase MOC. (*Id.* ¶ 93.) He wrote ABIM on June 6, 2009, among other things, that it was "unfair and outright discriminatory that practitioners certified on or after 1990 are the only ones required to certify" and that he was "interested in recertifying in my subspecialty [gastroenterology] and would do so provided that all are required to certify . . . ." (*Id.*) Manalo never received a response or even the courtesy of an acknowledgement of receipt of his email from ABIM, which terminated his certification in gastroenterology, in December 2010, after he again decided not to purchase MOC. (*Id.*)

St. Vincent told Manalo that he would lose his staff privileges unless he maintained his ABIM gastroenterology certification (which could only be maintained by purchasing MOC) and that ABIM certification was required by the St. Vincent Medical Staff bylaws. (*Id.* ¶ 95.) He was told that maintaining his ABIM certification was "also a requirement of many payers [insurance companies] to ensure reimbursement for your services." (*Id.*) Manalo offered to earn additional CME credits beyond what was required by the St. Vincent bylaws. (*Id.*) He was told, however, that this was not an acceptable alternative to ABIM certification and MOC. (*Id.*)

Manalo was terminated by St. Vincent effective December 31, 2010, due to his refusal to participate in MOC and purchase a renewal of his ABIM certification. (*Id.* ¶ 96.) He was also caused upon his termination to forfeit $33,514.60 in his St. Vincent Retirement Plan account. (*Id.*)

After looking for employment for several months, Manalo took a position in April 2011 as staff gastroenterologist at Jonathan M. Wainwright Memorial Veterans Affairs Medical Center

("Wainwright") in Walla Walla, Washington. (*Id.* ¶ 100.) His annual salary at Wainwright was $265,000, plus a $66,250 recruitment incentive, which was substantially less than the base salary of $400,000 he had been receiving at St. Vincent. (*Id.*) He remained at Wainwright until its gastroenterology practice closed in July 2017. (*Id.*) Despite actively searching for another position, he remains unemployed. (*Id.*) Although he is eligible for NPBAS certification, he was told by hospitals at which he sought employment that they recognized only ABIM certification and MOC. (*Id.* ¶ 101.) ABIM currently reports Manalo on its website as "Not Certified" even though he obtained initial certifications in internal medicine and gastroenterology. (*Id.*)

4. Katherine Murray-Leisure, MD

Murray worked with leprosy and syphilis patients as a Lieutenant JG in the Commissioned Corps of the United States Public Health Service. (*Id.* ¶ 103.) She investigated sand fly-borne leishmaniasis in veterans of Operation Desert Shield and Operation Desert Storm, a disease with ulcers of the skin or inside the nose with cyclic fevers and sometimes an enlarged spleen. (*Id.*) Murray and colleagues shared their medical research findings at microbiology and infections diseases meetings and with the Pennsylvania Medical Society, the American Medical Association, and the United States Congress. (*Id.*) She received national recognition from the United States Department of Veterans Affairs, Veterans of Foreign Wars, and the American Legion. (*Id.*) She has thirty peer-reviewed publications in the field of infectious diseases and is a member of the American Society of Tropical Medicine and the Infectious Diseases Society of America. (*Id.*) Murray is a past President of the Lebanon County Medical Society, Pennsylvania, and is currently a County Delegate for the Massachusetts Medical Society. (*Id.*)

Murray obtained an initial and lifelong board certification in internal medicine from ABIM in 1984. (*Id.* ¶ 104.) She purchased an infectious diseases subspecialty initial ABIM

certification in 1990. (*Id.*) Although Murray is "grandfathered" in internal medicine with a lifelong certification, ABIM did not "grandfather" her initial infectious diseases certification because it was purchased after 1990. (*Id.*) Murray was required to purchase infectious diseases MOC recertifications in 2000 and again ten years later in order to maintain her subspecialty certification. (*Id.* ¶ 105.) This required disruptive patient practice questionnaires, two years of test-taking practices, four years of meritless self-evaluation modules, and hours of examinations with standardized two-minute test questions at a remote test site under uncomfortable conditions. (*Id.*)

Murray was the infectious diseases ("ID") consultant and hospital epidemiologist for twenty years, from 1987–2007, at three hospitals in Lebanon, Pennsylvania: the Lebanon Veterans Administration Medical Center, Good Samaritan Hospital, and the Lebanon Valley General Hospital birthing facility. (*Id.* ¶ 106.) In 2010, Murray relocated from Pennsylvania back to Massachusetts, closer to her aging parents, and started infectious diseases consultations in Plymouth, Massachusetts. (*Id.*) She associated with another ID consultant at Beth Israel Deaconess Hospital-Plymouth ("BID-Plymouth") in the South Shore region of Massachusetts, then known as Jordan Hospital. (*Id.*) Holding privileges in infectious diseases at Jordan Hospital was a crucial part of Murray's practice. (*Id.* ¶ 107.)

The Jordan Hospital bylaws required that physicians holding staff privileges, such as Murray, be ABIM-certified in their area of specialty. (*Id.* ¶ 108.) Murray reviewed Jordan Hospital's bylaws, which exempted certain senior physicians, but required all new physicians to have an ABIM certification and participate in MOC in order to continue hospital work in their subspecialty. (*Id.*)

ABIM terminated Murray's infectious diseases certification after she did not pass her MOC examination in 2009. (*Id.* ¶ 109.) Despite strongly supportive patient and colleague recommendations, Murray's infectious disease privileges (but not her "grandfathered" internal medicine privileges) were revoked by Jordan Hospital in May 2011, consistent with the bylaws requirement that Murray maintain her ABIM certification and participate in MOC. (*Id.*) Murray later passed her MOC examination in May 2012, and her infectious diseases privileges were restored by Jordan Hospital. (*Id.* ¶ 111.)

Plaintiffs initiated this class action lawsuit in this Court on December 6, 2018. (Doc. No. 1.) An Amended Complaint was filed on January 23, 2019, asserting violations of Sections 1 and 2 of the Sherman Antitrust Act, Section 1962(c) of the RICO Act, and a claim of unjust enrichment. (Doc. No. 19.) ABIM filed its Motion to Dismiss the Amended Complaint on March 18, 2019. (Doc. No. 22.) Plaintiffs filed a Memorandum of Law in Opposition, (Doc. No. 28), and ABIM filed a Reply, (Doc. No. 31).

II. LEGAL STANDARD

A. Federal Rule of Civil Procedure 12(b)(6)

A motion to dismiss under Federal Rule of Civil Procedure 12(b)(6) tests the sufficiency of a complaint. *Kost v. Kozakiewicz*, 1 F.3d 176, 183 (3d Cir. 1993). "To survive a motion to dismiss, 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, 679 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)) (internal quotation marks omitted). In deciding a motion to dismiss under Rule 12(b)(6), courts must "accept as true all allegations in the complaint and all reasonable inferences that can be drawn from them after construing them in the light most favorable to the nonmovant." *Davis v. Wells Fargo*, 824 F.3d 333, 341 (3d Cir. 2016)

(quoting *Foglia v. Renal Ventures Mgmt., LLC*, 754 F.3d 153, 154 n.1 (3d Cir. 2014)) (internal quotation marks omitted). However, courts need not "accept mere[] conclusory factual allegations or legal assertions." *In re Asbestos Prods. Liab. Litig. (No. VI)*, 822 F.3d 125, 133 (3d Cir. 2016) (citing *Iqbal*, 556 U.S. at 678–79). "Threadbare recitals of the elements of a cause of action, supported by mere conclusory statements, do not suffice." *Twombly*, 550 U.S. at 555. Finally, we may consider "only the complaint, exhibits attached to the complaint, matters of public record, as well as undisputedly authentic documents if the complainant's claims are based upon [those] documents." *Davis*, 824 F.3d at 341 (quoting *Mayer v. Belichick*, 605 F.3d 223, 230 (3d Cir. 2010)) (internal quotation marks omitted).

B. Federal Rule of Civil Procedure 9(b)

In order to adequately plead fraud under Rule 9(b), a party "must plead with particularity 'the "circumstances" of the alleged fraud in order to place the [other party] on notice of the precise misconduct with which they are charged, and to safeguard the [other party] against spurious charges of immoral and fraudulent behavior.'" *Travelers Indem. Co. v. Cephalon, Inc.*, 620 F. App'x 82, 85 (3d. Cir. 2015) (quoting *Lum v. Bank of Am.*, 361 F.3d 217, 223–24 (3d Cir. 2004)). However, the United States Court of Appeals for the Third Circuit ("Third Circuit") has instructed courts not to focus exclusively on the narrow "particularity requirement," but also to consider the "general simplicity and flexibility contemplated by the rules." *Craftmatic Sec. Litig. v. Kraftsow*, 890 F.2d 628, 645 (3d Cir. 1989). In the case of corporate fraud, where a party "cannot be expected to have personal knowledge of the details of corporate internal affairs," a party may "accompany their allegations with facts indicating why the charges against [another party] are not baseless and why additional information lies exclusively within defendants'

control." *F.D.I.C. v. Bathgate*, 27 F.3d 850, 876 (3d Cir. 1994) (quoting *Craftmatic*, 890 F.2d at 646).

III. DISCUSSION

Plaintiffs' Amended Complaint alleges several claims against ABIM. Count I asserts ABIM violated Section 1 of the Sherman Act by unlawfully tying its initial certification, the "tying" product, and its MOC programs, the "tied" product. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 9–10.) Count II alleges a violation of Section II of the Sherman Act based on ABIM's "anticompetitive conduct," including unlawful tying, to obtain and maintain monopoly power. (*Id.* at 20.) In Count III, Plaintiffs contend that ABIM violated Section 1962(c) of the RICO Act by fraudulent misrepresentations that MCOs have a beneficial impact on physicians, patients, and the public. (*Id.* at 27–29.) Count IV alleges a claim of unjust enrichment. (*Id.* at 37.) We address these claims in this order below.

A. Plaintiffs Fail to Assert a Claim of Unlawful Tying under the Sherman Act

Section 1 of the Sherman Act states that "[e]very 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. "[A] tying arrangement may be defined as 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." *N. Pac. Ry. Co. v. United States*, 356 U.S. 1, 5–6 (1958). In order to state a *per se* claim of unlawful tying, a plaintiff must allege that: (1) a defendant seller ties "two distinct products;" (2) the purchase of the tying product is conditioned on the sale of the tied product; (3) the seller possesses market power in the tying product market to coerce purchasers into buying the tied product; and (4) a "not insubstantial amount of interstate

commerce is affected." *See Eastman Kodak Co. v. Image Technical Servs., Inc.*, 504 U.S. 451, 461–62 (1992) (citing *Fortner Enters., Inc. v. U.S. Steel Corp.*, 394 U.S. 495, 503 (1969)); *Jefferson Parish Hosp. Dist. No. 2. v. Hyde*, 466 U.S. 2, 21–22 (1984), *abrogated on other grounds by Ill. Tool Works Inc. v. Indep. Ink, Inc.*, 547 U.S. 28 (2006); *N. Pac. Ry. Co.*, 356 U.S. at 5–6.

The relevant element for our analysis is whether ABIM's initial certification is a separate product from its MOC offering. In its Motion to Dismiss, ABIM contends that its initial certification and MOC are not "distinct" products, but rather a single product. (Def.'s Mem. Law in Supp. Mot. Dismiss 9.) When evaluating whether the two products are "distinct," the court's analysis turns "not [on] a functional relation between them, but rather on the character of the demand for the two items." *Jefferson Parish*, 466 U.S. at 19. Meaning, there must be sufficient demand for the purchase of the tied, or unwanted, product separate from the tying, or wanted, product. *Id.* at 21–22. "Relevant evidence of separate and distinct consumer demand for the tying product and the tied product is, *inter alia*, the history of the products being, or not being, sold separately or the sale of the products separately in similar markets." *Kaufman v. Time Warner*, 836 F.3d 137, 142 (2d Cir. 2016) (internal citations omitted) (citing *United States v. Microsoft Corp.*, 253 F.3d 34, 85–89 (D.C. Cir. 2001); *Kodak*, 504 U.S. at 462).

In *Kodak*, the Supreme Court of the United States ("Supreme Court") found that Kodak's policy of selling replacement parts for micrographic and copying machines only to those who used Kodak Service or planned to repair their own machines was a potential tying arrangement. 504 U.S. at 458, 563. The Supreme Court found that Kodak's intent by not selling parts separate from service was to make it more difficult for third party companies to sell repair and maintenance services for Kodak's machines. *See id.* at 458. Moreover, the Court found that

sufficient consumer demand existed for either the machine services or parts. *See id.* at 463. Namely, it found that "[a]t least some consumers would purchase service without parts, because some service does not require parts, and some consumers, those who self-service for example, would purchase parts without service." *Id.* Therefore, the existence of two distinct markets for Kodak's separate products created a possible unlawful tying arrangement. *See id.*

Conversely, in *Kaufman*, a recent decision by the United States Court of Appeals for the Second Circuit ("Second Circuit"), the court found that there was no tying arrangement where the plaintiff alleged that a cable company required purchasers who bought a package of television channels to also lease the cable boxes necessary to transmit that programming. 836 F.3d at 140, 144. In addressing the plaintiff's allegations that cable boxes and television services are separate products, including that the cable company separately itemizes charges for leasing cable boxes and providing television services on consumers' bills, the Second Circuit stated that to be useful, "a cable box must be cable-provider specific, like the keys to a padlock," and, despite the allegation of a tie-in, "the core issue is a cable provider's right to refuse to enable cable boxes it does not control to unscramble its coded signal." *Id.* at 144. Accordingly, the court found that the plaintiffs were unable to show the existence of a demand for cable boxes separate from the television services. *See id.* at 145.

In the present case, Plaintiffs assert that separate demand exists for initial certification and MOC. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 10–14.) Plaintiffs offer five reasons to support their claim. First, Plaintiffs argue that the products were sold separately in the past, stating that "ABIM first sold initial certifications in 1936 and did not begin selling MOC until 1990." (*Id.* at 11 (citing *Kodak*, 504 U.S. at 462).) Second, Plaintiffs assert that there are other competitors, specifically NBPAS, that sell MOCs without selling the initial certification. (*Id.*)

Third, Plaintiffs claim that internists " 'differentiate between' ABIM's initial certification and MOC products" and, therefore, "have a desire to purchase a maintenance of certification product from providers other than ABIM." (*Id.* (citing Am. Compl. ¶¶ 55, 66).) Fourth, Plaintiffs contend that ABIM, itself, differentiates between the products due to ABIM's "practice of both charging for MOC fees separately and distinguishing between initial certification fees and MOC fees on its financial statements." (*Id.*) Finally, Plaintiffs raise the issue of ABIM's policy to "grandfather" internists who purchased initial certifications prior to 1990. (*Id.* at 12.) According to Plaintiffs, ABIM's grandfathering demonstrates that "[i]f ABIM considered initial certification and MOC to be components of a single product, it would not have freed 40% of ABIM-certified internists from buying MOC." (*Id.* at 12.)

We disagree with Plaintiffs and find that ABIM's initial certification and MOC products are part of a single product and do not occupy distinct markets. Not only are we unconvinced by Plaintiffs' arguments, we find that Plaintiffs' entire framing of the ABIM certification to be flawed. In essence, Plaintiffs are arguing that, in order to purchase ABIM's initial certification, internists are forced to purchase MOC products as well. However, this is not the case. As Plaintiffs state in their Amended Complaint, Kenney, Joshua, Manalo, and Murray were all able to purchase ABIM's initial certification without also buying MOC programs. (Am. Compl. ¶¶ 75 (Kenney), 83 (Joshua), 91 (Manalo), 104 (Murray).) Nowhere in the Amended Complaint do Plaintiffs allege that they were forced to buy MOC products in order to purchase the initial certification. In fact, some ultimately decided not to purchase MOC altogether.

This is because what internists are actually buying is ABIM certification. Initial certification is just that, *initial* certification for a specific period of time. (*Id.* ¶¶ 26–34.) In order to obtain the initial certification, internists must pass an "ABIM-administered examination" that

establishes that the internists have "met rigorous standards." (*Id.* ¶¶ 21–22.) The subsequent "maintenance of certification" program allows ABIM to ensure that those it has certified are still able to meet its "rigorous standards" and stay up-to-date on the general practice of internal medicine. (*Id.* ¶¶ 32–34 (highlighting the periodic maintenance programs required by ABIM).) Under the *Jefferson Parish* test, the "character of the demand" for the initial certification and the MOC is the same: certification from ABIM. Internists are not buying "initial certification" or "maintenance of certification," but rather ABIM certification. This is made clear by hospitals and other medical service providers requiring ABIM certification, in general. This fundamental misconception about the nature of the entire certification product offered by ABIM undercuts Plaintiffs' arguments.[2]

Moreover, addressing Plaintiffs' specific arguments, we start with their contention that the sales history supports their claim that initial certification and MOC products are separate because ABIM began selling initial certification "more than fifty years" before requiring MOC. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 11.) However, again this is misleading. While we accept that ABIM started selling initial certification without requiring MOC in 1935, ABIM did not develop and offer its first MOC-style program until 1974–75. (Am. Compl. ¶ 25.) Then,

[2] In its Memorandum of Law in Support, ABIM compares its certification process to several franchise cases. (Def.'s Mem. Law in Supp. Mot. to Dismiss 11–12.) For example, ABIM cites *Krehl v. Baskin-Robbins Ice Cream Co.*, in which the United States Court of Appeals for the Ninth Circuit rejected a tying claim where the ice cream franchisor tied the purchase of the ice cream to the purchase of the franchise trademark. 664 F.2d 1348, 1351 (9th Cir. 1982). The *Krehl* court held that the "desirability of the trademark and the quality of the product it represents are so inextricably interrelated . . . as to preclude any findings that the trademark is a separate item for tie-in purposes." *Id.* at 1354. While not a perfect comparator, the franchise model is very instructive in our analysis of ABIM's certification process. Both cases highlight the importance of allowing the company controlling the product to control the quality of the product. *See id.* ("The desirability of the trademark is . . . utterly dependent upon the perceived quality of the product it represents."). For an ice cream franchisor, it is important that it ensures that a customer that wishes to purchase that particular brand of ice cream at franchise location has the same experience as another customer at another location. *See id.* ("[S]ale of substandard products under the mark would dissipate . . . goodwill and reduce the value of the trademark."). Likewise, ABIM has an interest in ensuring that all ABIM-certified internists can meet and maintain the same standards and requirements. Otherwise, hospitals, insurance companies, and patients would lose faith in the ABIM certification process.

fifteen years later, in 1990, ABIM began to require MOC after the initial certification. (Pls. Mem. Law in Opp'n Mot. to Dismiss 11.) Meanwhile, Plaintiffs initially brought this case in late-2018, over 28 years after the MOC requirement. Thus, history shows that MOC has been a requirement of ABIM certification for longer than it has not. Therefore, we give the past sales history very little weight in Plaintiffs' favor in our analysis. *See Kodak*, 504 U.S. at 462 (examining past sales practices as only one element in determining whether products were distinct).

Plaintiffs' second and third arguments are related and, again, both misunderstand the product being offered. Because ABIM offers the certification, it has the right to ensure those standards are met. Through offering its own MOC program, ABIM has full control over the standards required to achieve certification. It would entirely alter the nature of the certification if outside vendors could re-certify internists and potentially disrupt the trust hospitals, patients, and insurance companies place on the ABIM certification.

While Plaintiffs assert that another organization, NBPAS, offers its own "maintenance of certification" program, they also state the NBPAS does not offer an "initial certification" or require an applicant to meet any set of standards. (Am. Compl. ¶ 56; Pls.' Mem. Law in Opp'n Mot. to Dismiss 11–12.) While NBPAS might offer a cheaper maintenance of certification program, it is not a sufficient program to maintain ABIM certification. (Am. Compl. ¶ 59 ("ABIM does not recognize NBPAS maintenance of certification.").) While they may be functionally similar as a type of continuing education program, ABIM's MOC and NBPAS maintenance of certification offering are clearly not the same product, as they are not "maintaining" the same certification. (*Id.*) For example, much like a university has a right to ensure that students who earn a degree have met certain requirements set by that university,

ABIM has a right to ensure it is certifying internists that meet ABIM's standards. Because ABIM has no control over how NBPAS evaluates those seeking a certification, it would be unfair to ABIM and the internists that passed ABIM's MOC to allow other internists to maintain the same certification through an outside, and possibly inferior, third-party process. Therefore, there is no viable alternative program to ABIM's MOC program that is at a competitive disadvantage because of ABIM's requirement.

Plaintiffs' fourth argument highlights ABIM's practice of listing initial certification and MOC as separate products on billing statements and other financial documents. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 12.) In support of this argument, Plaintiffs cite *Jefferson Parish*, 466 U.S. at 22, and *Thompson v. Metropolitan Multi-List, Inc.*, 934 F.2d 1566, 1575 (11th Cir. 1991). First, *Jefferson Parish* is distinguishable from the facts of this case. There, the Supreme Court briefly mentioned that the defendant-hospital was listing its hospital services separately from the anesthesiological services. *See Jefferson Parish*, 466 U.S. at 22. However, in finding no tying arrangement because of a lack of coercion, the Court noted that both services were part of the same transaction. *See id.* at 25. However, here, there is no indication in the Amended Complaint that internists purchase their initial certification at the same time they purchase MOC programs.

As for *Thompson*, the United States Court of Appeals for the Eleventh Circuit cited separate billing practices as merely one example of evidence of separate services offered by separate entities. 934 F.2d at 1570, 1575–76. Plaintiffs make no such claim as to a separate entity tying their product to the purchase of ABIM's initial certification or MOC products. Therefore, *Thompson* is not instructive in this case.

Finally, Plaintiffs allege that ABIM does not consider MOC to be a requirement of initial certification because it has "grandfathered" those that purchased a lifetime certification prior to 1990. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 13.) However, Plaintiffs provide no support as to why ABIM should not be allowed to modify its certification process over time. We see no problem that at some point ABIM realized there was a need to have its certified internists undergo an MOC program, whether because the internists could not keep up with the advances in their particular field, saw their skills diminish, or any other reason. In fact, the need to require a MOC program is highlighted in this case, as Murray initially failed her infectious disease MOC program in 2009 and Joshua was unable to pass her required MOC program in 2014. (Am. Compl. ¶¶ 85, 109.)

We are unconvinced by Plaintiffs' arguments that ABIM's initial certification and MOC programs are distinct products. Plaintiffs' failure to establish two products means there can be no unlawful tying arrangement and we need not continue our analysis. *See Kaufman*, 836 F.3d at 142 ("[I]f there is no separate market for the allegedly tied product, there can be no fear of leveraging a monopoly in one market to harm competition in a second market. The second market simply does not exist."). Therefore, ABIM's Motion to Dismiss Plaintiffs Section 1 claim is granted. Count I of the Amended Complaint is dismissed with prejudice.[3]

[3] According to Federal Rule of Civil Procedure 15, "a party may amend its pleading once as a matter of course"; otherwise they must have consent from the opposing party or leave from the court. Fed. R. Civ. P. 15(b). Leave to amend shall be freely given. *Id.* However, the Third Circuit has held that the District Court may deny an opportunity to amend where the amendment would be futile. *See Alvin v. Suzuki*, 227 F.3d 107, 121 (3d Cir. 2000) (citing *Smith v. NCAA*, 139 F.3d 180, 190 (3d Cir. 1998), *rev'd on other grounds*, 525 U.S. 459 (1999); *Centifanti v. Nix*, 865 F.2d 1422, 1431 (3d Cir. 1989)). "An amendment is futile if the amended complaint would not survive a motion to dismiss for failure to state a claim upon which relief could be granted." *Id.* at 121. In deciding this issue, the District Court "applies the same standard of legal sufficiency as under [Federal Rule of Civil Procedure] 12(b)(6)." *See Smith*, 139 F.3d at 190 (citing *In re Burlington Coat Factory*, 114 F.3d 1410, 1434 (3d Cir. 1997)).

As there are no separate markets at issue in this case, it would be futile for Plaintiffs to amend its unlawful tying claim. Therefore, Count I is dismissed with prejudice.

B. Plaintiffs are Unable to Establish any Anticompetitive Conduct to Support a Monopolization Claim under the Sherman Act

Section 2 of the Sherman Act states that "[e]very person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons to monopolize any part of the trade or commerce among the several states, or with foreign nations, shall be deemed guilty of a felony . . . ." 15 U.S.C. § 2. In order to assert a violation of Section 2 against a defendant, the plaintiff must establish two elements: "(1) the possession of monopoly power in the relevant market and (2) the willful acquisition or maintenance of that power as distinguished from growth or development as a consequence of a superior product, business acumen, or historic accident." *See United States v. Grinnell Corp.*, 284 U.S. 563, 570–71 (1966).

The Supreme Court defines monopoly power as "the power to control prices or exclude competition" and may be "inferred from the predominant share of the market." *See id.* (quoting *United States v. E.I. du Pont De Nemours & Co.*, 351 U.S. 377, 391 (1956)).

Here, Plaintiffs assert that "ABIM maintains and abuses its monopoly power" of the MOC market on a basis other than the merits of the product. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 20.) Plaintiffs include several allegations of unfair conduct, however, a majority of them revolve around ABIM's supposed monopoly in the "maintenance of certification market." (*Id.* at 20–21.) As we described above, ABIM's MOC product is not a separate market, but rather a part of its offering in the overall certification market. ABIM cannot have a monopoly in a market that does not exist.

However, Plaintiffs do provide two allegations that, at least tangentially, relate to the overall certification market. Namely, that "ABIM's board of directors includes active participants in the market for internists' services and related markets with their own private anticompetitive motives to restrain competition" and that "ABIM deceives the public, including

hospitals, insurance companies, medical corporations, and other employers that MOC has a beneficial impact. Thus, internists must purchase [certification] to obtain hospital privileges, insurance reimbursement, employment, malpractice coverage, and other requirements of the practice of medicine." (*Id.* at 21.)

While these two allegations are not initially invalidated by their reliance on the non-existent MOC market, they are still unconvincing. Plaintiffs' assertion concerning ABIM's unnamed board members is a mere conclusory allegation that is insufficient to defeat a motion to dismiss. *See W. Penn Allegheny Health Sys., Inc. v. UPMC*, 627 F.3d 85, 103–04 (3d Cir. 2010). In what is only a single, passing line in Plaintiffs' Amended Complaint, they fail to provide the names of any ABIM board member or how they have used their position as "active participants in the market for internists' services and related markets" to pursue anticompetitive behavior for the benefit of ABIM. (Am. Compl. ¶ 71.) While there is no heightened pleading standard in antitrust cases, "some claims require more factual explication than others to state a plausible claim for relief." *W. Penn Allegheny Health*, 627 F.3d at 98 (quoting *In re Ins. Brokerage Antitrust Litig.*, 618 F.3d 300, 320 n.18 (3d Cir. 2010)); *but see Hosp. Bldg. Co. v. Trs. of Rex Hosp.*, 425 U.S. 738, 746 (1976) (citing *Poller v. Columbia Broad.*, 368 U.S. 464, 473 (1962); *Conley v. Gibson*, 355 U.S. 41, 45–46 (1957)) ("We have held that 'a complaint should not be dismissed for failure to state a claim unless it appears beyond doubt that the plaintiff can prove no set of facts in support of his claim which would entitle him to relief. And in antitrust cases, where 'the proof is largely in the hands of the alleged conspirators,' dismissals prior to giving the plaintiff ample opportunity for discovery should be granted very sparingly.").

Plaintiffs argue that the Supreme Court applies a "rigorous standard" for antitrust case dismissals and recognizes the need for discovery for certain types of anticompetitive conduct.

See id. However, this allegation is far too broad and would subject unnamed board members to indiscriminate discovery requests left to the whim of Plaintiffs.

Meanwhile, Plaintiffs' allegation concerning ABIM's supposed deception of "hospitals, insurance companies, medical corporations, and other employers" is also unavailing. (Pls.' Mem. Law in Opp'n Mot. to Dismiss 21.) This claim shares common factual allegations with Plaintiffs RICO claim in Count III and will be further addressed in more detail below. However, we address it here in the antitrust context.

Essentially, Plaintiffs assert ABIM waged a "successful campaign" to deceive the public that MOC "benefits physicians, patients and the public and constitutes self-regulation by internists." (Am. Compl. ¶ 6.) In turn, this has allegedly led hospitals, insurance companies, and other such medical providers to more frequently require internists to purchase and maintain ABIM certification as a condition for employment or reduced medical malpractice insurance premiums. (*Id.* ¶¶ 37–40.) Plaintiffs believe this must be deceptive because there is "no evidence of an actual causal relationship between MOC and any beneficial impact on physicians, patients or the public." (*Id.* ¶¶ 42–43.) However, in support, Plaintiffs merely put forth several public marketing materials from ABIM. (Am. Compl. ¶¶ 133–38.) There is no claim that ABIM actually deceived or coerced any hospital into requiring its internists to be ABIM-certified.

Rather, the Amended Complaint, itself, provides more reasonable and legitimate explanations as to why hospitals and medical service providers require ABIM certification, such as ABIM's long established history of certification and its creation of a national standard to compare internists from different states. To the extent ABIM has market power over the certification industry, we find that the Amended Complaint states no anticompetitive conduct on the part of ABIM. Therefore, ABIM's Motion to Dismiss the Amended Complaint is granted

with respect to Plaintiffs' Section 2 claim. Count II of the Amended Complaint is dismissed without prejudice.

C. Plaintiffs Fail to Assert a Proper RICO Claim

Turning to Plaintiffs' RICO claim, we note that Plaintiffs provide supplemental background material in their Amended Complaint to support this allegation. (*Id.* ¶¶ 131–61.) We accept Plaintiffs' additional assertions as true for the purposes of deciding this motion, many of which are specific, allegedly fraudulent, false, and misleading, statements, as well as, a summary of relevant statistics, financial information, and organizational structure. However, we decline to repeat those allegations here for the sake of relevancy and brevity, as ABIM does not move for dismissal on grounds related to much of the information provided.

Instead, ABIM argues Plaintiffs' RICO claim should be dismissed for two reasons. First, ABIM argues that Plaintiffs lack standing to bring this claim, as they have not suffered an economic injury as a direct result of ABIM's conduct. (Def.'s Mem. Law in Supp. Mot. to Dismiss 20–26.) Second, ABIM asserts that Plaintiffs failed to plead a fraud-based claim with sufficient peculiarity as required by Federal Rule of Civil Procedure 9(b). (*Id.* at 26–27.)

Standing to assert a RICO claim requires two prongs: (1) a plaintiff must show that they have suffered an injury to their business or property; and (2) the injury was directly related to the conduct of defendant's alleged RICO violation. *See In re Avandia Mktg., Sales Practices & Prods. Liab. Litig.*, 804 F.3d 633, 638 (3d Cir. 2015) (citing 18 U.S.C. § 1964). "[A] showing of injury requires proof of a concrete financial loss, and not mere injury to a valuable intangible property interest." *Id.* (quoting *Maio v. Aetna, Inc.*, 221 F.3d 472, 483 (3d Cir. 2000)).

In the present case, it is difficult to discern what Plaintiffs claim as their relevant injuries. Looking, initially, at the supplemental background provided under the Amended Complaint's

RICO count, there are no specific allegations concerning Kenney, Joshua, Manalo, or Murray, or any monetary injury sustained. Instead, there is a claim that Plaintiffs were "forced to pay MOC-related fees," (Am. Compl. ¶ 163), and a generic claim that "Plaintiffs have been injured in their business and property," (*Id.* ¶ 171). However, the Amended Complaint, in its entirety, includes more detailed information on potential injury claims. For instance, MNPG was forced to postpone Kenney's start date by six months so that he could pass the MOC examination, thus causing Kenney, who had already given his notice at his then-current job, to be without income for at least that much time. (*Id.* ¶¶ 78–79.) Kenney then decided that he had to turn down the MNPG offer altogether. (*Id.*) Joshua lost consulting and admitting privileges at five hospitals affiliated with DMC in 2014 after failing the MOC examination. (*Id.* ¶ 85.) Likewise, Joshua eventually lost her BCBS insurance coverage because of her lapsed ABIM certification and was effectively limited to outpatient care. (*Id.* ¶ 88.) St. Vincent terminated Manalo's employment at the end of 2010 due to his refusal to participate in MOC and purchase a renewal of his certification. (*Id.* ¶ 96.) As a result, Manalo was unemployed for several months and was eventually forced to accept a job for a substantially lower salary. (*Id.* ¶ 100.) Finally, Jordan Hospital revoked Murray's infectious disease privileges after she did not pass her MOC examination in 2009. (*Id.* ¶ 109.) This supposedly led to a loss in consulting income and reputational harm for Murray, despite passing the examination in 2012. (*Id.* ¶¶ 111–13.)

From this review, it is apparent that these potential injuries can be broken down into claims for "money spent," namely on MOC fees and associated costs[4] (though a sufficient tallying of such costs per individual is absent from the Amended Complaint), and "money lost," such as salary from diminished responsibilities or employment prospects. With respect to MOC

[4] Notably, this does not include Manalo, as he refused to purchase an MOC program. (Def.'s Mem. Law in Supp. Mot. to Dismiss 19; Am. Compl. P 93.)

fees, ABIM contends that those Plaintiffs that purchased MOC programs received the full benefit of said programs and that Plaintiffs merely have "buyers' remorse." (Def.'s Mem. Law in Supp. Mot. to Dismiss 24–25 (citing *In re Johnson & Johnson Talcum Powder Prods. Mktg., Sales Practices & Liab. Litig.*, 903 F.3d 278, 281 (3d Cir. 2018)).) However, Plaintiffs attempt to distinguish their injury by arguing that they were "forced to purchase MOC or have their certification terminated by ABIM." (Pls.' Mem. Law in Opp'n Mot. to Dismiss 34–35.) Plaintiffs insist that they either did not "want to buy MOC at all, or desire[d] to purchase it from a provider other than ABIM, such as NBPAS." (*Id.* at 35.)

Again, Plaintiffs' understanding of this issue is fundamentally flawed. First, as we have repeatedly discussed above, it is impossible to maintain an ABIM certification through the use of a non-ABIM maintenance program, as ABIM has the right to control who it is certifying and what standards and requirements are necessary. Second, ABIM has not forced Plaintiffs to purchase MOC. Instead, Plaintiffs purchased a product—certification—from ABIM for a period of time. When it came time to renew the certification, Plaintiffs were clearly able to decline to maintain their certifications knowing that their certifications will lapse. (*See, e.g.*, Am. Compl. ¶ 77 ("[Kenney's ABIM certification in gastroenterology] was scheduled to be terminated by ABIM effective December 31, 2017. He had already decided by this time, however, not to take the MOC examination again . . . .").) At no point did ABIM require or "force" Plaintiffs to purchase MOC. To the extent Plaintiffs were required to purchase MOC, it was at the urging of their employers or prospective employers.

Similarly, it is clear that Plaintiffs' loss of employment opportunities or job responsibilities were also a result of their employers' actions. The employers established ABIM-certification as a performance requirement for their internists. Plaintiffs were either unable or

unwilling to meet that requirement and suffered adverse actions because of it. The Amended Complaint contains no allegations that ABIM had any control over internist-requirements at the Plaintiffs' employers. *See Anza v. Ideal Steel Supply Corp.*, 547 U.S. at 460 ("When a court evaluates a RICO claim for proximate causation, the central question it must ask is whether the alleged violation led directly to the plaintiff's injuries.").

Therefore, because there are numerous reasons why Plaintiffs' employers would require internists to hold an ABIM certification beyond ABIM's marketing materials, ABIM's alleged fraudulent statements are too attenuated to substantiate a claim. ABIM's Motion to Dismiss the Amended Complaint is granted with respect to Plaintiffs' RICO claim. Count III of the Amended Complaint is dismissed without prejudice.

D. Plaintiffs Fail to State a Claim for Unjust Enrichment

Finally, ABIM moves to dismiss Plaintiffs' claim for unjust enrichment. In order to state a claim for unjust enrichment, a plaintiff must show that: (1) the plaintiff conferred a benefit on the defendant; (2) the defendant appreciated the benefit; and (3) the acceptance and retention by the defendant of the benefits, under the circumstances, would make it inequitable for the defendant to retain the benefit without paying for the value of the benefit. *See Global Ground Supp., LLC v. Glazer Enters., Inc.*, 581 F. Supp. 2d 669, 675 (E.D. Pa. 2008) (quoting *Torchia v. Torchia*, 499 A.2d 581, 582 (1985) ("[T]o sustain a claim of unjust enrichment, a claimant must show that the party against whom recovery is sought either wrongfully secured or passively received a benefit that it would be unconscionable for her to retain.")).

ABIM argues, in part, that Plaintiffs received the benefit of their bargain because they have not shown that they failed to receive the MOC programs they purchased. (Def.'s Mem. Law in Supp. Mot. to Dismiss 30.) Contrarily, Plaintiffs allege that "they conferred a benefit on

ABIM (their MOC-related fees), that ABIM wrongfully obtained those fees by forcing Plaintiffs and other internists to purchase MOC or have their certifications terminated, and that it would be unjust for ABIM to retain MOC fees obtained as a result of its unlawful conduct." (Pls.' Mem. Law in Opp'n Mot. to Dismiss 37.)

Our analysis is again constrained by Plaintiffs' misunderstanding of the product they purchased. Clearly, the first two elements of unjust enrichment are met for Plaintiffs that purchased MOC. However, the third element is not met because it is not inequitable for ABIM to keep the benefit since it did not "force" Plaintiffs to purchase MOC. Plaintiffs were, of course, free to decide to no longer be certified by ABIM and to, therefore, not purchase MOC. In fact, it would be inequitable for Plaintiffs to demand ABIM continue to certify them without proving they are still able to meet ABIM standards and without paying ABIM for the MOC program.

Therefore, ABIM's Motion to Dismiss is granted with respect to Plaintiffs' claim of unjust enrichment. Count IV of the Amended Complaint is dismissed with prejudice.[5]

IV. CONCLUSION

For the reasons stated above, Defendants' Motion to Dismiss the Amended Complaint is granted. Plaintiffs' claims of illegal monopolization and monopoly maintenance under Section 2 of the Sherman Act in Count II and Section 1962(c) violations of the RICO Act in Count III are dismissed without prejudice. Plaintiffs' claims of unlawful tying under Section 1 of the Sherman Act in Count I and unjust enrichment in Count IV are dismissed with prejudice. Plaintiffs shall have fourteen days to file a Second Amended Complaint.

An appropriate Order follows.

[5] Allowing leave to amend this claim would be futile as the Amended Complaint makes apparent that Plaintiffs were not coerced or "forced" to buy MOC programs. *See Alvin*, 227 F.3d at 121.