ORAL ARGUMENT NOT YET SCHEDULED

NO. 10-5057

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

AMERICAN BAR ASSOCIATION,

Plaintiff-Appellee,

v.

FEDERAL TRADE COMMISSION,

Defendant-Appellant.

On Appeal From the United States District Court For the District of Columbia
Civil Action No. 1:09-cv-01636 (RBW)

AMICUS CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION, AMERICAN OSTEOPATHIC ASSOCIATION, AMERICAN COLLEGE OF PHYSICIANS, AMERICAN CONGRESS OF OBSTETRICIANS AND GYNECOLOGISTS, AMERICAN SOCIETY OF CATARACT AND REFRACTIVE SURGERY, ILLINOIS OSTEOPATHIC MEDICAL SOCIETY, MEDICAL SOCIETY OF THE DISTRICT OF COLUMBIA, MISSOURI ASSOCIATION OF OSTEOPATHIC PHYSICIANS AND SURGEONS, OHIO OSTEOPATHIC ASSOCIATION, AND OSTEOPATHIC PHYSICIANS AND SURGEONS OF OREGON IN SUPPORT OF APPELLEE

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CERTIFICATE AS TO PARTIES, RULINGS AND RELATED CASES

A. Parties and *Amici*. With the exception of the *amici* on whose behalf this brief is filed, all parties and *amici* appearing before the district court and in this Court are listed in the Brief for Appellant Federal Trade Commission.

B. Rulings Under Review. The rulings under review are the December 1, 2009 Amended Order on summary judgment and the December 28, 2009 final Judgment of the Hon. Reggie B. Walton of the United States District Court for the District of Columbia in *American Bar Association v. Federal Trade Commission*, Civ. No. 1:09-cv-01636. The district court's Amended Order granted partial summary judgment to the American Bar Association ("ABA") on its claim that the Federal Trade Commission exceeded its statutory authority, in violation of the Administrative Procedure Act, 5 U.S.C. § 706(2)(C), by issuing an Extended Enforcement Policy applying the FTC's Red Flags Rule, 16 C.F.R. § 681.1, to lawyers engaged in the practice of law. Following the ABA's agreement to dismiss its remaining claims without prejudice, the district court issued a Judgment declaring the FTC's Extended Enforcement Policy unlawful as applied to attorneys and enjoining the FTC from applying the Red Flags Rule to attorneys.

C. Related Cases. The case on review has not previously been before this Court or any other United States Court of Appeals. Two related cases are pending in the United States District Court for the District of Columbia. The first,

Am. Inst. of Certified Pub. Accountants v. FTC, Civ. No. 1:09-cv-02116-RBW (D.D.C.), challenges application of the Red Flags Rule to accountants. The second, *AMA, et al. v. FTC*, No. 1:10-cv-00843-RBW (D.D.C.), challenges application of the Red Flags Rule to physicians.

/s/ Jack R. Bierig
JACK R. BIERIG

Attorney for Amici Curiae

CORPORATE DISCLOSURE STATEMENTS

Pursuant to Circuit Rules 12(f), 26.1, and 29(b), *amici* Medical Associations make the following disclosures:

American Medical Association (AMA)

The AMA is the largest national professional association of physicians, residents, and medical students. Through state and specialty medical societies, and other physician groups seated in the AMA's House of Delegates, substantially all physicians in the United States participate in developing AMA policy. AMA's mission is to promote the art and science of medicine and the betterment of public health. Among the basic purposes of the AMA is to safeguard the patient-physician relationship, which is fundamental to quality patient care. In addition, the AMA seeks to protect members from undue government interference in their medical practices – particularly where government regulation does not lower cost or improve patient care. The AMA appears in its own capacity and as a representative of the Litigation Center, which was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts in accordance with AMA policies and objectives. A not-for-profit corporation organized under the laws of Illinois, the AMA is headquartered at 515 N. State Street, Chicago, IL 60654. The AMA has

no parent company and no publicly-held company has an ownership interest in the AMA.

American Osteopathic Association (AOA)

The AOA is a national professional association representing more than 67,000 doctors of osteopathic medicine. The AOA's mission is to advance the philosophy and practice of osteopathic medicine by promoting excellence in education, research, and the delivery of quality, cost-effective health care within a distinct, unified profession. The AOA seeks to protect its members from unwarranted government regulation of osteopathic medicine and its members' practices. The AOA is a not-for-profit corporation organized under the laws of the state of Illinois. Its headquarters are at 142 East Ontario Street, Chicago, IL 60611. The AOA has no parent company, and no publicly-held company holds an ownership interest in the AOA.

American College of Physicians, Inc. (ACP)

ACP is a national organization of internists – physicians who specialize in the prevention, detection, and treatment of illnesses in adults. ACP is the largest medical-specialty organization and second-largest physician group in the United States. Its membership of 130,000 includes internists, internal medicine subspecialists, and medical students, residents, and fellows. ACP's Mission is to enhance the quality and effectiveness of health care by fostering excellence and

professionalism in the practice of medicine. ACP is a non-profit corporation organized and existing under the laws of Delaware with its headquarters located at 190 North Independence Mall West, Philadelphia, Pennsylvania. ACP has no corporate parent and no publicly-held corporation has an ownership interest in ACP.

American Congress of Obstetricians and Gynecologists (ACOG)

ACOG is a private, voluntary, nonprofit membership organization with over 52,000 members and is the nation's leading group of professionals providing health care for women. ACOG serves as a strong advocate for quality health care for women and works to maintain the highest standards of clinical practice and continuing education for its members. In addition, ACOG works to protect its members from undue government regulation of their practices. ACOG's headquarters are located in Washington, D.C. ACOG has no parent company, and no publicly-held company holds an ownership interest in ACOG.

American Society of Cataract and Refractive Surgery (ASCRS)

With approximately 10,000 members, ASCRS is the nation's leading professional society of physicians providing anterior segment specialty care in ophthalmology. Founded in 1974, ASCRS promotes the science and art of ophthalmology and seeks to ensure that patients receive the highest quality innovative eye care. ASCRS is a not-for-profit organization headquartered at 4000

Legato Road, Suite 700, Fairfax, Virginia 22033. ASCRS has no parent company and no publicly-held company holds an ownership interest in ASCRS.

Illinois Osteopathic Medical Society (IOMS)

The IOMS is an Illinois not-for-profit corporation that represents more than 3,300 osteopathic physicians, surgeons, and medical students in the State of Illinois. Founded in 1902, the IOMS advocates on behalf of osteopathic physicians in Illinois and their patients; provides high-quality continuing medical education across the State of Illinois; and offers professional networking opportunities to members. IOMS has no parent company, and no publicly-held company holds an ownership interest in IOMS.

Medical Society of the District of Columbia (MSDC)

The MSDC is a state medical society with representation in the AMA House of Delegates. MSDC has approximately 2,000 physician members, most of whom practice in the District of Columbia and surrounding counties. MSDC seeks to promote the well-being of physicians in metropolitan Washington, D.C. and their patients, to establish high standards of character and professionalism, and to safeguard the integrity of the physician-patient relationship. Like the AMA, the MSDC appears in its own capacity and as a representative of the Litigation Center. A not-for-profit corporation founded in 1817 and chartered by an Act of Congress in 1819, MSDC has its headquarters at 1115 30th Street, NW, Washington, DC

20007. The MSDC has no parent company, and no publicly-held company holds an ownership interest in MSDC.

Missouri Association of Osteopathic Physicians and Surgeons (MAOPS)

MAOPS, a Missouri not-for-profit corporation, represents the interests of osteopathic medicine in the State of Missouri, including the more than 2,300 osteopathic physicians who practice in the State, more than 1000 students who are enrolled in the accredited osteopathic medical schools in Kirksville and Kansas City, and osteopathic physicians completing their professional training in residency and fellowship programs throughout the State of Missouri. The mission of MAOPS is to preserve the osteopathic profession in the state of Missouri and serve its members in their quest to provide the highest quality of osteopathic medical care to the citizens of that State. MAOPS has no parent company, and no publicly-held company holds an ownership interest in MAOPS.

Ohio Osteopathic Association (OOA)

Founded in 1898, the OOA is an Ohio non-profit corporation that represents more than 4,600 licensed osteopathic physicians, 18 health care facilities accredited by the American Osteopathic Association, and the Ohio University College of Osteopathic Medicine in Athens, Ohio. OOA's objectives include the promotion of Ohio's public health and maintenance of high standards at all

osteopathic institutions within the State. OOA has no parent company, and no publicly-held company holds an ownership interest in OOA.

Osteopathic Physicians and Surgeons of Oregon (OPSO)

The OPSO, established in 1917, is the voice of the osteopathic profession in Oregon. OPSO is dedicated to the principle that excellence and integrity are essential to quality patient care. OPSO provides advocacy, leadership, and educational opportunities for more than 700 osteopathic physicians who practice in Oregon and provide care to citizens of the state. OPSO is dedicated to promoting the causes, needs, goals, and advancement of osteopathic medicine in Oregon. OPSO has no parent company, and no publicly-held company holds an ownership interest in OPSO.

CERTIFICATE OF NECESSITY OF SEPARATE BRIEF

Pursuant to Circuit Rule 29(d), the undersigned counsel states that it was necessary to file a separate brief on behalf of the Medical Associations serving as *amici curiae* in this appeal because the issues that they raise concerning the Federal Trade Commission's application of the Red Flags Rule to physicians are distinct and deserving of separate treatment from the arguments raised by *amicus curiae* the American Institute of Certified Public Accountants on behalf of accountants and the New York State Bar Association on behalf of attorneys.

/s/ Jack R. Bierig
JACK R. BIERIG

Attorney for Amici Curiae

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GLOSSARY

ABA	American Bar Association
AMA	American Medical Association
AOA	American Osteopathic Association
Commission	Federal Trade Commission
FACT Act	Fair and Accurate Credit Transactions of 2003
FTC	Federal Trade Commission
HHS	U.S. Department of Health and Human Services

STATUTES AND REGULATIONS

Except for the statutes included in the addendum attached to this brief, all of the pertinent statutes and regulations are included in the brief of the Federal Trade Commission and the brief of the American Bar Association.

STATEMENT OF INTEREST OF *AMICI CURIAE*

This case concerns the Red Flags Rule, 72 Fed. Reg. 63,718 (Nov. 9, 2007) (codified at 16 C.F.R. § 681.1), JA 46, which the FTC promulgated under Title I of the Fair and Accurate Credit Transactions Act of 2003 (the "FACT Act"), Pub. L. 108-159, 117 Stat. 1952. Nearly eighteen months later, on April 30, 2009, the Commission issued an "Extended Enforcement Policy" that stated that the agency will treat "professionals, such as lawyers or health care providers, who bill their clients after services are rendered" as "creditors" subject to the Red Flags Rule. *Extended Enforcement Policy* at 1 n.3, JA 62a.

The *amici curiae* on whose behalf this brief is filed (the "Medical Associations") are associations of physicians who must comply with the Red Flags Rule under the Commission's Extended Enforcement Policy. The Medical Associations believe that extension of the Rule to any physician who does not require payment at the time of service exceeds the Commission's authority under the FACT Act, was effectuated in violation of the Administrative Procedure Act, needlessly raises the cost of health care, and tends to undermine the patient-physician relationship. Accordingly, certain of the Medical Associations have filed suit to enjoin application of the Red Flags Rule to physicians. *See AMA, et*

al. v. FTC, Case No. 1:10-cv-00843 (D.D.C. filed May 21, 2010).[1] Recognizing the impact that this appeal will have on that case, the district court ordered, upon the parties' stipulation, that the case be stayed pending this Court's opinion in this appeal.

PRELIMINARY STATEMENT

In the decision below, the district court held that the FTC may not apply the Red Flags Rule to attorneys because attorneys are not "creditors" and their clients are not "customers" or "account holders" within the meaning of the FACT Act. *ABA v. FTC*, 671 F. Supp. 2d 64, 88 (D.D.C. 2009). Both in the district court and here, the FTC argues that extension of the Red Flags Rule to attorneys is authorized by (a) the broad "sweep" of the FACT Act's definition of "creditor" and (b) the absence of a provision exempting any industry or profession from the Act's scope. (FTC Br. at 21-22). Specifically, the Commission contends that the definition of "creditor" in the Act was meant "to sweep in all entities that deferred billing to their clients or customers." (FTC Br. at 28). The FTC repeatedly expresses its view that the FACT Act's "sweep" captures, in addition to attorneys, any physician who does not collect payment in full from each patient at the time of care. (*See id.* at 8, 12 & nn.14-15, 23 n.19, 27 n.22, 35, 41).

[1] Plaintiffs are the American Medical Association, the American Osteopathic Association, and the Medical Society of the District of Columbia.

In this brief, *amici* Medical Associations will demonstrate that FTC's broad interpretation of the FACT Act is erroneous. Specifically, we will show that Title I of the Act, on which the Red Flags Rule is predicated, cannot reasonably be read to cover physicians. Therefore, the basic premise of the Commission's argument, *i.e.* that the FACT Act extends to all professionals without exception, is incorrect. Accordingly, to apply the Red Flags Rule to attorneys, the Commission would have to point to specific language in FACT Act – a showing that it cannot make.

SUMMARY OF ARGUMENT

The plain language of Title I of the FACT Act demonstrates that the Commission has no authority to apply the Red Flags Rule to professionals. Initially, a decision not to demand payment at the time of service does not make a professional a "creditor" for purposes of the Act. Moreover, clients and patients of professionals are neither "account holders" nor "customers" within the meaning of the Act.

The effort of the Commission to characterize professionals as "creditors" and their clients and patients as "customers" runs afoul of the principle that, given the traditional regulation of the professions by the states, Congress must speak explicitly when it chooses to regulate in this area. Thus, when Congress has determined to regulate privacy and confidentiality issues in the medical context, it has done so directly and specifically. Indeed, in Title IV of the FACT Act itself,

Congress did address privacy issues – and did so with explicit reference to "health care providers." The fact that Congress referred specifically to "health care providers" in Title IV but referred only to "creditors" in Title I is further proof that Congress did not intend the Red Flags Rule to cover physicians (or other professionals).

Finally, strong policy considerations support the decision by Congress not to subject professionals to the Red Flags Rule. There is no indication in the legislative history that identity theft is a significant problem in the professional context. Thus, requiring physicians to have a written policy on identity theft and to train their staffs on such a policy serves only to raise the cost of health care. Most significantly, imposing a requirement that physicians must greet each new patient with skepticism by checking the patient's identity is in tension with establishment of a patient-physician relationship built on trust – a relationship that is critical to effective patient care.

ARGUMENT

I. THE TEXT OF THE FACT ACT DEMONSTRATES THAT THE FTC HAS NO STATUTORY AUTHORITY TO APPLY THE RED FLAGS RULE TO PROFESSIONALS

The FACT Act directs the FTC to adopt guidelines for use by each "financial institution" and "creditor" regarding identity theft "with respect to account holders at, or customers of, such entities." FACT Act, Title I, § 114

(codified at 15 U.S.C. § 1681m(e)(1)(A)). Likewise, the Act authorizes the FTC to require by regulation each "financial institution" or "creditor" to adopt policies and procedures to identify risks posed to "account holders or customers or to the safety and soundness of the institution or customers." *Id.* (codified at 1681m(e)(1)(B)). The FTC does not contend that professionals are "financial institutions." (FTC Br. at 21). Thus, the initial question is whether Congress intended the term "creditor" to include attorneys (and other professionals).

The FACT Act defines a "creditor" as a "person who regularly extends, renews, or continues credit." FACT Act, § 111 (codified at 15 U.S.C. § 1681a(r)(4)) (incorporating the definition of "creditor" in 15 U.S.C. § 1691a(d)). In turn, the term "credit" is defined as "the *right* granted by a creditor to a *debtor* to defer payment of debt or to incur debts and defer its payment or to purchase property or services and defer payment therefor." *Id.* (incorporating the definition of "credit" in 15 U.S.C. § 1691a(e)) (emphasis added). As the ABA brief demonstrates (at 40), attorneys who do not demand payment at the time of services do not fall within the definition of "creditor" because they do not grant a debtor the right to defer payment.

Likewise, a physician whose practice is to bill for services after the services are provided is not a "creditor" by virtue of not demanding payment at the time of treatment. Nothing in such a billing arrangement confers upon the patient a "right"

to "defer" payment once presented with the bill or to insist that a bill be presented at a later date. These circumstances are in stark contrast to credit card agreements, the paradigmatic provision of "credit." There, the card holder has the right to purchase services and pay the credit card company at a later, fixed date some or all of the cost of those services, deferring any remaining amount owed.

Rather, physicians bill for services after they are provided for many reasons unrelated to the extension of credit. In many cases, the amount that an insured patient will have to pay is not certain until the patient's health insurance carrier provides an explanation of the amount that the patient owes the physician – taking into account any deductible, co-payment, and the like. It does not serve patients to demand payment for the full cost up front and force the patient to seek a refund from the insurer.

Further, post-service billing underscores the physician's fiduciary relationship to the patient and distinguishes that relationship from ordinary commercial transactions. Thus, it furthers the patient-physician relationship. In addition, physicians also provide emergency medical care to patients whose identifying information may be unknown and who may even be unconscious. It would violate principles of ethical conduct for a physician to demand payment at the time of service in such situations. In short, the deferral of payment in the

medical context has nothing to do with "credit," and everything to do with a physician's duty to provide medical care in an ethical and professional manner.

Beyond the inapplicability of the word "creditor," the Commission's reading of Section 114 of the FACT Act is flawed for a second reason: It ignores the limiting phrase, "with respect to account holders at, or customers of" financial institutions and creditors. The statutory reference to "account holders" and "customers" confirms that the Red Flags Rule is not properly applied to professionals.

Initially, patients of physicians and clients of attorneys are not generally thought of as "customers." While the FACT Act does not define "customers," that word is commonly understood to refer to purchasers of goods or services from commercial businesses – not to patients of physicians or clients of attorneys. Indeed, it is almost comical to suggest that physicians discussing an individual under their care might say, "I have a question about the treatment of this customer." Similarly, an attorney would raise eyebrows by representing to a court, "My customer in this matter is …."

Likewise, physicians and attorneys are not "account holders" of their patients and clients, respectively. Although the FACT Act does not define "account holders," the word "account" is defined by incorporating the definition in § 903 of the Electronic Fund Transfer Act ("EFTA"). FACT Act, Title I, § 111

(codified at 15 U.S.C. § 1681a(r)(4)). That statute defines an "account" as "a demand deposit savings deposit, or other asset account." 15 U.S.C. § 1693a(2). Unlike banks with respect to their customers, physicians do not hold the assets of their patients. Thus, patients are not "account holders" within the meaning of the FACT Act. Similarly, clients are generally not account holders of attorneys.[2]

The Commission's focus on the word "creditor" depends on the erroneous proposition that the governing statute ends with the phrase "guidelines for use by each financial institution and each creditor regarding identity theft" (with no further language) – or that the statute requires "guidelines for use by each financial institution and each creditor with respect to anyone with whom it has dealings." But that proposition ignores the inconvenient truth that the relevant sentence concludes with the phrase "with respect to account holders at, or customers of" financial institutions or creditors. The Commission's failure persuasively to address that phrase demonstrates the error of the agency's position. It is a cardinal principle of statutory construction that statutes "ought, upon the whole, to be so construed that, if it can be prevented, no clause, sentence, or word shall be superfluous, void, or insignificant." *Duncan v. Walker*, 533 U.S. 167, 174 (2001); *accord City of Portland v. EPA*, 507 F.3d 706, 711 (D.C. Cir. 2007).

[2] If attorneys do hold the assets of clients, they typically do so in accounts at financial institutions pursuant to trust agreements. Notably, trust agreements are expressly excluded from the definition of "account" under 15 U.S.C. § 1693a(2).

In sum, physicians are not "creditors," and their patients are not "account holders" or "customers." Post-service billing arrangements do not represent the extension of "credit" as defined in the FACT Act. Therefore, the FTC's interpretation of the FACT Act must fail.

II. ADDITIONAL PRINCIPLES OF STATUTORY CONSTRUCTION CONFIRM THAT THE FTC HAS NO AUTHORITY TO APPLY THE RED FLAGS RULE TO PROFESSIONALS

In addition to the text of the FACT Act, several principles of statutory construction reinforce the conclusion that Congress did not intend for physicians, attorneys, or other professionals to be subject to the Red Flags Rule.

First, the professions have traditionally been regulated by the states. Thus, when Congress intends to regulate the practice of law or the practice of medicine, it does so explicitly. With respect to physicians, the Supreme Court has explained that, "given the structure and limitations of federalism," when "Congress wants to regulate medical practice in the given scheme, it does so by explicit language in the statute." *Gonzalez v. Oregon*, 546 U.S. 243, 270, 272 (2006). The "background principles of our federal system belie the notion that Congress would use … an obscure grant of authority to regulate areas traditionally supervised by the States' police power." *Id.* at 274.

These "background principles of federalism" undercut the FTC's arguments. As the Commission would have it, Congress authorized the agency to regulate

physicians in their relationships with patients through the unlikely mechanism of employing the term "creditor" in the FACT Act. This is hardly the "explicit language" envisioned by the Supreme Court. Moreover, the Commission's reliance on staff interpretations of regulations promulgated by a different federal agency (the Federal Reserve Board) concerning a different regulatory term ("incidental credit") promulgated under a different statute (the Equal Credit Opportunity Act) with a different purpose (anti-discrimination) does not qualify as a clear congressional directive in the FACT Act.

Notably, when Congress wishes to regulate physicians with respect to their patients' privacy and confidentiality, it does so explicitly. For example, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. Law. 104-191, 110 Stat. 1936, directs the Secretary of Health and Human Services ("HHS") to promulgate rules to ensure that a "health care provider" who utilizes electronic billing and payment methods protects against "unauthorized uses or disclosures of" patients' health information and guards against "reasonably anticipated threats or hazards to the security or integrity of the information." 42 U.S.C. §§ 1320d-1(a)(3) & (d), 1320d-2(d). Similarly, Congress requires health care providers who are "covered entities" under HIPAA to notify HHS and affected patients of any unauthorized access, use, or disclosure of protected health information that has not been encrypted or otherwise rendered unreadable in ways set forth in HHS

guidelines. Health Information Technology for Economic and Clinical Health ("HITECH") Act, Pub. L. 111-5, § 13402, 123 Stat. 115,260 (codified at 42 U.S.C. § 17932).

Perhaps most tellingly, Congress expressly addressed health care providers in a separate Title of the FACT Act. Specifically, Title IV of that Act limits the use of "medical information" in credit transactions and protects the identity of "medical information furnishers" in consumer reports. FACT Act, Title IV, §§ 411, 412, 117 Stat. 1952, 1999-2003. "Medical information" is defined as information provided by a "health care provider" that relates to "the provision of health care to an individual" or the "payment for the provision of health care to an individual." *Id.*§ 411(c) (codified at 15 U.S.C. § 1681a(i)). Similarly, "medical information furnisher" is defined as "a person whose primary business is providing medical services, products, or devices [and] who furnishes information to a consumer reporting agency." *Id.* § 412(c) (codified at 15 U.S.C. § 1681s-2(a)(9)).

The explicit reference in Title IV to "health care provider" and "the provision of health care to an individual" belies any argument that health care providers are to be considered "creditors" and patients are to be considered "customers" under Title I. Congress would not refer to physicians as "health care providers" in Title IV while referring to them by the inappropriate term "creditors" in Title I. *See Barnhart v. Sigmon Coal Co.*, 534 U.S. 438, 452 (2002) ("[W]hen

Congress includes particular language in one section of a statute but omits it in another section ... , it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." (quotations omitted)).

Indeed, the Commission's argument that a "health care provider" is a "creditor" and that post-service billing constitutes the extension of "credit" under Title I of the FACT Act would lead to absurd results. Specifically, Title IV of the Act provides that, unless specifically authorized by federal law or regulation, "a creditor shall not obtain or use medical information pertaining to a consumer … in connection with any determination of the consumer's eligibility, or continued eligibility, for credit." FACT Act, Title IV, § 411(a) (codified in relevant part at 15 U.S.C. § 1681b(g)(2)). Under the FTC's interpretation of "creditor" and "customer," this provision could be read as follows: "A physician shall not obtain or use medical information pertaining to a patient in connection with any determination of whether to bill the patient after services are rendered." Congress could not have intended this result. *See Bilski v. Kappos*, 130 S. Ct. 3218, 3228-29 (2010) (rejecting an interpretation of one section of the Patent Act based on its implications for another section of the Act).

In sum, principles of statutory construction regarding Congressional regulation of the professions and the full text of the FACT Act confirm that Congress did not intend for the FTC to regulate professionals under the Act.

III. SOUND PUBLIC POLICY SUPPORTS THE DECISION OF CONGRESS NOT TO GRANT THE FTC AUTHORITY TO APPLY THE RED FLAGS RULE TO PROFESSIONALS

The decision by Congress not to have the FACT Act authorize application of the Red Flags Rule to professionals is supported by sound policy. On one hand, as noted by the ABA (Br. at 29–30), nothing in the legislative history suggests that identity theft is a significant problem in the professional context. Moreover, compliance with the rule by physicians can be expected to increase the cost of health care since each medical practice will have to develop written policies on identity theft and train and oversee staff compliance with those policies. *See* 16 C.F.R. § 681.1(d)(1), (e)(3).

On the other hand, mandatory checking of the identity of new patients or clients is in tension with the development of the trust relationship that is vital to the delivery of professional services. The importance of a trust relationship is particularly critical in the medical context. Such a relationship is essential if a patient is to confide in a physician the often unpleasant or embarrassing facts necessary for sound diagnosis (*e.g.*, sexual history, psychiatric issues, unhealthy habits).

Imposition of a legal duty to investigate each new patient's identity in advance of treatment conflicts with basic precepts regarding the patient-physician

relationship and physicians' ethical responsibilities to establish and safeguard that relationship. The AMA has stated the point as follows:

> "From ancient times, physicians have recognized that the health and well-being of patients depends upon a collaborative effort between physician and patient …. The patient-physician relationship is of greatest benefit of patients when they bring medical problems to the attention of their physicians in a timely fashion, provide information about their medical condition to the best of their ability, and work with their physicians in a mutually respectful alliance."

Ethical Opinion 10.015 ("The Patient-Physician Relationship"). *See also* AOA, *Code of Ethics* § 3 ("A physician-patient relationship must be founded on mutual trust, cooperation, and respect.").

Contrary to these precepts, the FTC's Extended Enforcement Policy requires physicians to meet each new patient with skepticism about his or her identity. This attitude compromises a physician's ability to develop that trust relationship which is essential to effective diagnosis and treatment. At a minimum, it gets the relationship off in a regulatory, rather than a collaborative, spirit.

Under the Commission's interpretation of the FACT Act, a physician who wants to avoid this impediment to establishing a sound patient-physician relationship would have to require all patients to pay in full at the time of service. Such conduct, however, would not serve the interests of the patient and would create significant administrative issues with third party payors. Surely, if Congress

had intended to mandate this result, it would have spoken explicitly – and with consideration of the relevant issues reflected in the legislative history.

CONCLUSION

For the foregoing reasons and those set forth in the brief of appellee American Bar Association, the decision of the district court should be affirmed.

Respectfully Submitted,

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Dated: September 3, 2010

CERTIFICATE OF COMPLIANCE

In accordance with Fed. R. App. P. 32(a)(7)(C)(i), I certify that the foregoing *Amicus* Brief contains 3,362 words, not including the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii) and Circuit Rule 32(a)(2), and complies with the type-volume limitations of Fed. R. App. P. 29(d) and 32(a)(7)(B).

This brief has been prepared in proportionally spaced typeface using Microsoft Word 2007 in Times New Roman, 14 pt. typeface and complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6).

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CERTIFICATE OF SERVICE

Pursuant to Fed. R. of App. P. 25(c)(1), Circuit Rule 25(c), and this Court's Administrative Order Regarding Electronic Case Filing, ECF-2(D) and ECF-7, I hereby certify that, each party to the case having consented to electronic service, I served a copy of the foregoing *Amicus* Brief and Addendum on the individuals below by filing the same on the Court's CM/ECF system on September 3, 2010.

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ADDENDUM

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United States Code Annotated Currentness
Title 15. Commerce and Trade
Chapter 41. Consumer Credit Protection (Refs & Annos)
Subchapter III. Credit Reporting Agencies (Refs & Annos)
→ § 1681a. Definitions; rules of construction

(a) Definitions and rules of construction set forth in this section are applicable for the purposes of this subchapter.

***

(i) Medical information

The term "medical information"--

(1) means information or data, whether oral or recorded, in any form or medium, created by or derived from a health care provider or the consumer, that relates to--

(A) the past, present, or future physical, mental, or behavioral health or condition of an individual;

(B) the provision of health care to an individual; or

(C) the payment for the provision of health care to an individual. [FN2]

(2) does not include the age or gender of a consumer, demographic information about the consumer, including a consumer's residence address or e-mail address, or any other information about a consumer that does not relate to the physical, mental, or behavioral health or condition of a consumer, including the existence or value of any insurance policy.

***

(r) Credit and debit related terms

(4) Account and electronic fund transfer

The terms "account" and "electronic fund transfer" have the same meanings as in section 1693a of this title.

United States Code Annotated Currentness
Title 15. Commerce and Trade
Chapter 41. Consumer Credit Protection (Refs & Annos)
Subchapter III. Credit Reporting Agencies (Refs & Annos)
➡ **§ 1681b. Permissible purposes of consumer reports**

***

(g) Protection of medical information

***

(2) Limitation on creditors

Except as permitted pursuant to paragraph (3)(C) or regulations prescribed under paragraph (5)(A), a creditor shall not obtain or use medical information (other than medical information treated in the manner required under section 605(a)(6) of this title) pertaining to a consumer in connection with any determination of the consumer's eligibility, or continued eligibility, for credit.

***

United States Code Annotated Currentness
Title 15. Commerce and Trade
Chapter 41. Consumer Credit Protection (Refs & Annos)
Subchapter III. Credit Reporting Agencies (Refs & Annos)
§ 1681s-2. Responsibilities of furnishers of information to consumer reporting agencies

(a) Duty of furnishers of information to provide accurate information

***

(9) Duty to provide notice of status as medical information furnisher

A person whose primary business is providing medical services, products, or devices, or the person's agent or assignee, who furnishes information to a consumer reporting agency on a consumer shall be considered a medical information furnisher for purposes of this subchapter, and shall notify the agency of such status.

***

United States Code Annotated Currentness
Title 15. Commerce and Trade
Chapter 41. Consumer Credit Protection (Refs & Annos)
Subchapter VI. Electronic Fund Transfers (Refs & Annos)
→ § 1693a. Definitions

As used in this subchapter--

***

(2) the term "account" means a demand deposit, savings deposit, or other asset account (other than an occasional or incidental credit balance in an open end credit plan as defined in section 1602(i) of this title), as described in regulations of the Board, established primarily for personal, family, or household purposes, but such term does not include an account held by a financial institution pursuant to a bona fide trust agreement;

***

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 156. Health Information Technology
Subchapter III. Privacy
Part A. Improved Privacy Provisions and Security Provisions

§ 17932. Notification in the case of breach

(a) In general

A covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information (as defined in subsection (h)(1)) shall, in the case of a breach of such information that is discovered by the covered entity, notify each individual whose unsecured protected health information has been, or is reasonably believed by the covered entity to have been, accessed, acquired, or disclosed as a result of such breach.

(b) Notification of covered entity by business associate

A business associate of a covered entity that accesses, maintains, retains, modifies, records, stores, destroys, or otherwise holds, uses, or discloses unsecured protected health information shall, following the discovery of a breach of such information, notify the covered entity of such breach. Such notice shall include the identification of each individual whose unsecured protected health information has been, or is reasonably believed by the business associate to have been, accessed, acquired, or disclosed during such breach.

(c) Breaches treated as discovered

For purposes of this section, a breach shall be treated as discovered by a covered entity or by a business associate as of the first day on which such breach is known to such entity or associate, respectively, (including any person, other than the individual committing the breach, that is an employee, officer, or other agent of such entity or associate, respectively) or should reasonably have been known to such entity or associate (or person) to have occurred.

(d) Timeliness of notification

(1) In general

Subject to subsection (g), all notifications required under this section shall be made without unreasonable delay and in no case later than 60 calendar days after the discovery of a breach by the covered entity involved (or business associate involved in the case of a notification required under subsection (b)).

(2) Burden of proof

The covered entity involved (or business associate involved in the case of a notification required under subsection (b)), shall have the burden of demonstrating that all notifications were made as required under this part, including evidence demonstrating the necessity of any delay.

(e) Methods of notice

(1) Individual notice

Notice required under this section to be provided to an individual, with respect to a breach, shall be provided promptly and in the following form:

(A) Written notification by first-class mail to the individual (or the next of kin of the individual if the individual is deceased) at the last known address of the individual or the next of kin, respectively, or, if specified as a preference by the individual, by electronic mail. The notification may be provided in one or more mailings as information is available.

(B) In the case in which there is insufficient, or out-of-date contact information (including a phone number, email address, or any other form of appropriate communication) that precludes direct written (or, if specified by the individual under subparagraph (A), electronic) notification to the individual, a substitute form of notice shall be provided, including, in the case that there are 10 or more individuals for which there is insufficient or out-of-date contact information, a conspicuous posting for a period determined by the Secretary on the home page of the Web site of the covered entity involved or notice in major print or broadcast media, including major media in geographic areas where the individuals affected by the breach likely reside. Such a notice in media or web posting will include a toll-free phone number where an individual can learn whether or not the individual's unsecured protected health information is possibly included in the breach.

(C) In any case deemed by the covered entity involved to require urgency because of possible imminent misuse of unsecured protected health information, the covered entity, in addition to notice provided under subparagraph (A), may provide information to individuals by telephone or other means, as appropriate.

(2) Media notice

Notice shall be provided to prominent media outlets serving a State or jurisdiction, following the discovery of a breach described in subsection (a), if the unsecured protected health information of more than 500 residents of such State or jurisdiction is, or is reasonably believed to have been, accessed, acquired, or disclosed during such breach.

(3) Notice to Secretary

Notice shall be provided to the Secretary by covered entities of unsecured protected health information that has been acquired or disclosed in a breach. If the breach was with respect to 500 or more individuals than such notice must be provided immediately. If the breach was with respect to less than 500 individuals, the covered entity may maintain a log of any such breach occurring and annually submit such a log to the Secretary documenting such breaches occurring during the year involved.

(4) Posting on HHS public website

The Secretary shall make available to the public on the Internet website of the Department of Health and Human Services a list that identifies each covered entity involved in a breach described in subsection (a) in which the unsecured protected health information of more than 500 individuals is acquired or disclosed.

(f) Content of notification

Regardless of the method by which notice is provided to individuals under this section, notice of a breach shall include, to the extent possible, the following:

(1) A brief description of what happened, including the date of the breach and the date of the discovery of the breach, if known.

(2) A description of the types of unsecured protected health information that were involved in the breach (such as full name, Social Security number, date of birth, home address, account number, or disability code).

(3) The steps individuals should take to protect themselves from potential harm resulting from the breach.

(4) A brief description of what the covered entity involved is doing to investigate the breach, to mitigate losses, and to protect against any further breaches.

(5) Contact procedures for individuals to ask questions or learn additional information, which shall include a toll-free telephone number, an e-mail address, Web site, or postal address.

(g) Delay of notification authorized for law enforcement purposes

If a law enforcement official determines that a notification, notice, or posting required under this section would impede a criminal investigation or cause damage to national security, such notification, notice, or posting shall be delayed in the same manner as provided under section 164.528(a)(2) of title 45, Code of Federal Regulations, in the case of a disclosure covered under such section.

(h) Unsecured protected health information

(1) Definition

(A) In general

Subject to subparagraph (B), for purposes of this section, the term "unsecured protected health information" means protected health information that is not secured through the use of a technology or methodology specified by the Secretary in the guidance issued under paragraph (2).

(B) Exception in case timely guidance not issued

In the case that the Secretary does not issue guidance under paragraph (2) by the date specified in such paragraph, for purposes of this section, the term "unsecured protected health information" shall mean protected health information that is not secured by a technology standard that renders protected health information unusable, unreadable, or indecipherable to unauthorized individuals and is developed or endorsed by a standards developing organization that is accredited by the American National Standards Institute.

(2) Guidance

For purposes of paragraph (1) and section 17937(f)(3) of this title, not later than the date that is 60 days after February 17, 2009, the Secretary shall, after consultation with stakeholders, issue (and annually update) guidance specifying the technologies and methodologies that render protected health information unusable, unreadable, or indecipherable to unauthorized individuals, including the use of standards developed under section 300jj-12(b)(2)(B)(vi) of this title.

(i) Report to Congress on breaches

(1) In general

Not later than 12 months after February 17, 2009 and annually thereafter, the Secretary shall prepare and submit to the Committee on Finance and the Committee on Health, Education, Labor, and Pensions of the Senate and the Committee on Ways and Means and the Committee on Energy and Commerce of the House of Representatives a report containing the information described in paragraph (2) regarding breaches for which notice was provided to the Secretary under subsection (e)(3).

(2) Information

The information described in this paragraph regarding breaches specified in paragraph (1) shall include--

(A) the number and nature of such breaches; and

(B) actions taken in response to such breaches.

(j) Regulations; effective date

To carry out this section, the Secretary of Health and Human Services shall promulgate interim final regulations by not later than the date that is 180 days after February 17, 2009. The provisions of this section shall apply to breaches that are discovered on or after the date that is 30 days after the date of publication of such interim final regulations.

United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XI. General Provisions, Peer Review, and Administrative Simplification (Refs & Annos)
Part C. Administrative Simplification
→ § 1320d-1. General requirements for adoption of standards

(a) Applicability

Any standard adopted under this part shall apply, in whole or in part, to the following persons:

(1) A health plan.

(2) A health care clearinghouse.

(3) A health care provider who transmits any health information in electronic form in connection with a transaction referred to in section 1320d-2(a)(1) of this title.

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(d) Implementation specifications

The Secretary shall establish specifications for implementing each of the standards adopted under this part.

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United States Code Annotated Currentness
Title 42. The Public Health and Welfare
Chapter 7. Social Security (Refs & Annos)
Subchapter XI. General Provisions, Peer Review, and Administrative Simplification (Refs & Annos)
Part C. Administrative Simplification
§ 1320d-2. Standards for information transactions and data elements

***

(d) Security standards for health information

(1) Security standards

The Secretary shall adopt security standards that--

(A) take into account--

(i) the technical capabilities of record systems used to maintain health information;

(ii) the costs of security measures;

(iii) the need for training persons who have access to health information;

(iv) the value of audit trails in computerized record systems; and

(v) the needs and capabilities of small health care providers and rural health care providers (as such providers are defined by the Secretary); and

(B) ensure that a health care clearinghouse, if it is part of a larger organization, has policies and security procedures which isolate the activities of the health care clearinghouse with respect to processing information in a manner that prevents unauthorized access to such information by such larger organization.

(2) Safeguards

Each person described in section 1320d-1(a) of this title who maintains or transmits health information shall maintain reasonable and appropriate administrative, technical, and physical safeguards--

(A) to ensure the integrity and confidentiality of the information;

(B) to protect against any reasonably anticipated--

(i) threats or hazards to the security or integrity of the information; and

(ii) unauthorized uses or disclosures of the information; and

(C) otherwise to ensure compliance with this part by the officers and employees of such person.

***