Case No. 129081

In the
Illinois Supreme Court

Lucille Mosby, individually and on behalf of all others similarly situated,

Plaintiff-Appellee,

v.

The Ingalls Memorial Hospital, UCM Community Health & Hospital Divisions, Inc., and Becton, Dickinson and Company,

Defendants Appellants.

Yana Mazya, individually and on behalf of all others similarly situated,

Plaintiff-Appellee,

v.

Northwestern Lake Forest Hospital, Northwestern Memorial Healthcare, Omnicell, Inc., and Becton, Dickinson and Company,

Defendants-Appellants.

On Appeal from the Appellate Court of Illinois,
First Judicial District, Case Nos. 1-20-0822 & 1-21-0895 (Cons.),
There on Appeal from the Circuit Court of Cook County, Illinois, County Department, Chancery Division, Case Nos. 18 CH 5031 & 18 CH 7161,
Hon. Pamela McLean Meyerson & Hon. Alison C. Conlon, Judges Presiding.

BRIEF OF *AMICI CURIAE* ADVOCATE HEALTH AND HOSPITALS CORPORATION, ADVENTIST MIDWEST HEALTH, GOOD SAMARITAN HOSPITAL – MT. VERNON, LOYOLA UNIVERSITY HEALTH SYSTEM, MEMORIAL HEALTH SYSTEM, NORTHSHORE UNIVERSITY HEALTHSYSTEM, RUSH UNIVERSITY SYSTEM FOR HEALTH, AND ST. MARY'S HOSPITAL – CENTRALIA

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INTEREST OF THE *AMICI*

Advocate Health and Hospitals Corporation, Adventist Midwest Health, Good Samaritan Hospital – Mt. Vernon, Loyola University Health System, Memorial Health System, Northshore University Healthsystem, Rush University System for Health, and St. Mary's Hospital – Centralia ("*Amici*") are among the largest and most respected health care providers in the state, collectively serving the majority of the millions of patients treated in Illinois health care facilities each year. They are not-for-profit entities with the shared mission of providing the highest quality care to their patients and improving the health and wellbeing of the communities they serve. As with other health care providers in Illinois, *Amici* have a valuable real-world understanding of: (1) the treatment, payment, and operational uses of the technology at issue in this case; and (2) the consequences that hospitals, patients, and Illinois communities will suffer if the appellate court majority's decision is affirmed. *Amici* respectfully submit this brief to assist the Court's deliberations by presenting facts, insights, and practical realities on these points, which are largely beyond the record, and may be helpful to having a rounded understanding of the dispute and the stakes involved in the manner of its resolution.

ARGUMENT

This case is ultimately about whether the Illinois legislature intended for the Biometric Information Privacy Act, 740 ILCS 14/1 *et seq.* ("BIPA"), and

its potentially annihilative damages regime, to apply to health care providers using biometric technology in the provision of patient care.[1] The answer to that question is no. While the desire to safeguard control over personal biometric information motivated BIPA's enactment (*Rosenbach v. Six Flags Entertainment Corp.*, 2019 IL 123186, ¶ 34), there is no reason to conclude that the legislature blindly pursued this objective to absurd and ruinous ends.

As discussed below, a decision affirming the appellate court majority here would potentially expose Illinois health care providers to *hundreds of billions of dollars* in cumulative liability, dwarfing the market capitalization or other valuations of even the largest hospital systems and providers. Such liability would result in hospital closings and diminish Illinois residents' already-insufficient access to health care, especially in underserved urban and rural communities. This Court recently emphasized in another BIPA case that "statutes should be interpreted with the presumption that the legislature did not intend absurd, inconvenient, or unjust consequences when enacting the statute." *Tims v. Black Horse Carriers, Inc.*, 2023 IL 127801, ¶ 22 (cleaned up). Reading BIPA in a manner that could impose crippling liability on hospitals and hamper patient care, can only be viewed as exactly the kind of absurdity

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[1] *Amici* use the term "biometric technology" for ease and consistency of reference, as that is the term plaintiffs use in the operative pleadings. *Amici* understand from the record that the factual question of whether the technology at issue qualifies as "biometric" is disputed, but that question is not immediately relevant to this appeal.

this Court must presume was not intended. Indeed, the legislature had good reason to exempt hospitals from BIPA's reach in certain limited circumstances.

I. Automated dispensing cabinets utilizing biometric technology are critical to providing modern medical treatment, to ensuring accurate billing, and to improving hospital operations.

Automated dispensing cabinets, variously referred to as "ADCs," "medstations," or by their brands (*e.g.*, "Pyxis" or "Omnicell" devices), are machines that allow medical professionals to quickly, safely, and securely manage medication near the point of care. ADCs are much more than storage cabinets. Among other functions, they:

- facilitate the timely administration of medication to patients;
- help ensure patients receive the correct doses and mixes of medication;
- provide secure storage of controlled substances and prevent unauthorized access to controlled substances;
- electronically track the use and distribution of those substances;
- support clinical review of medication orders by pharmacists before administration to reduce negative interactions;
- facilitate more accurate billing; and
- help automate the timely restocking of needed medications.

See Craig A. Petersen *et al.*, *National Survey of Pharmacy Practice in Hospital Settings: Dispensing and Administration–2020*, 78 Am. J. Health-Sys. Pharmacy 1074, 1076–77 (2021); Matthew Grissinger, *Safeguards for Using and Designing Automated Dispensing Cabinets*, 37 P&T J. 490, 490–91 (Sept.

2012); Esther Y. Fung & Belling Leung, *Do Automated Dispensing Machines Improve Patient Safety?*, 62 Can. J. Hosp. Pharmacy 516 (Nov.-Dec. 2009).

ADCs are almost universally used in modern health care.

Because of their considerable utility, ADCs are ubiquitous in the United States, deployed in hospitals, surgical centers, pharmacies, residential care facilities, rehabilitation facilities, group homes, dentists' offices, and veterinary offices, among other places. The use of ADCs now represents the "standard of care" for handling and distributing medication in modern medicine, and they are considered "essential to provid[ing] quality patient care, secur[ing] storage of medications, and ensur[ing] viability of the medication-use process in healthcare organizations." Ryan Cello *et al.*, *ASHP [American Society of Health-System Pharmacists] Guidelines on the Safe Use of Automated Dispensing Cabinets*, 79 Am. J. Health-Sys. Pharmacy e71, e71 (Jan. 2022).

The vast majority of hospitals surveyed nationwide use ADCs as their primary method for distributing medication to patients. *State of Pharmacy Automation, Results from PP&P's 2022 National Survey*, Pharmacy Purchasing & Prod. Mag., Aug. 2022, at 8, 48; Cello *et al.*, *supra*, at e71; Petersen *et al.*, *supra*, at 1076. Illinois has followed this trend, with a recent (publicly-available) settlement agreement revealing that 64% of medical facilities in Illinois use the Omnicell device alone, which is just one of several major manufacturers of ADCs utilizing biometric technology. *See Heard v.*

Omnicell, Inc., Case No. 2019 CH 6817 (Cir. Ct. Cook Cty, Mar. 23, 2023) (Plaintiff's Unopposed Motion for Final Approval of Class Actions Settlement). The Pyxis device, which is at issue in this case, is another ADC device commonly used in Illinois.

Medication distribution before ADCs was cumbersome, less secure, and led to unnecessarily negative treatment and operational outcomes.

The widespread adoption of ADCs in recent years has been driven by a great and ever-growing need for the services they provide. Hospitals and other care facilities traditionally had centralized pharmacies and medication distribution systems, which had significant limitations and drawbacks. For instance, centralized systems created bottlenecks in the distribution of needed medications, especially in larger hospitals. Petersen *et al.*, *supra*, at 1091. In order to give a patient prescribed medication, nurses were previously required to go to the hospital pharmacy or "med room," or else find a charge nurse who had restricted access to a locked medication pantry. This inefficient routine might have to be repeated several times a day for each patient, multiplied by the number of patients under care, negatively impacting patient care.

As demand for medical services grew, it became clear to medical practitioners that this centralized drug distribution system could not keep pace. The traditional system slowed patient care and thereby resulted in unnecessarily negative treatment outcomes. Petersen *et al.*, *supra*, at 1091. It also limited the number of patients a facility could treat at any given time, artificially restricting access to health care services.

The centralized drug distribution system had other unintended consequences as well. Physical and temporal distances between central points of drug distribution (*e.g.*, pharmacies) and the point of care (patients' bedsides) made medications less secure. *Id.* There were numerous ways controlled substances could be "diverted" (*i.e.*, stolen) in transit from patients, leading to negative treatment outcomes. Medications could be replaced by products with similar appearances, syringe contents could be replaced with saline solutions, medications could be documented but not administered, and more. John Clark *et al.*, *ASHP Guidelines on Preventing Diversion of Controlled Substances*, 79 Am. J. Health-Sys. Pharmacy 2279, 2280 (Dec. 2022).

This was not simply a question of theft of valuable and oft-abused drugs (such as opioids) by health care workers impacting hospital operations.[2] Diversion directly resulted in patient harm as well. *Id.* at 2279. Drug diversion meant that patients might not receive the full dosage of their prescribed medications, or they might not receive the needed medications at all. Those patients would then have inaccurate medication histories in their medical records, causing physicians to make treatment decisions based on bad information. *Id.* Those same patients might also later be presented with inaccurate bills for medications they never or only partially received. *Id.* And,

[2] It is estimated that 10% to 15% of health care workers in the United States misuse alcohol or drugs at some point in their careers. Clark, *et al.*, *supra* at 2279.

of course, treatment outcomes might be negatively impacted if the treaters were themselves impaired by using diverted medications. *Id.*

ADCs with biometric access allow health care providers to better treat patients, bill more accurately, and operate more efficiently.

The advent and adoption of ADCs with biometric technology largely solved these and other related problems by decentralizing the distribution of medication, while simultaneously making it more secure. Instead of having to go to the pharmacy or med room every time a drug is needed, a nurse or other treater can have immediate access to medication already stored near the patient's room. ADC usage decreased the intervals between the prescription and administration of medications, decreased the intervals between ongoing administrations of medications, and reduced the incidence of diversion. The incorporation of biometric technology over analogue systems, such as passcodes, similarly reduced treatment and operational delays that frequently occurred when even authorized personnel forgot their access information.

These improvements led to better patient outcomes and recovery times, which proved especially important in emergency rooms and intensive care units, where fast access to controlled substances and quick turnaround times are imperative due to limited bed counts. *See* Riikka Metsämuuronen *et al.*, *Nurses' Perceptions of Automated Dispensing Cabinets – An Observational Study and an Online Survey*, 19 BMC Nursing J. 27 (Apr. 2020); Mark Ragoo, *Using a Fingerprint Access Medication Cabinet to Improve Efficiency in an Emergency Department*, 33 Emergency Med. J. 926 (Nov. 2016); Elsa Bourcier

et al., *Implementation of Automated Dispensing Cabinets for Management of Medical Devices in an Intensive Care Unit: Organizational and Financial Impact*, 23 Eur. J. Hosp. Pharmacy 86 (Mar. 2016).

ADCs thus not only allow health care providers to better treat their patients, they also allow facilities to treat more patients by increasing operational efficiencies. ADCs likewise allow health care providers to track and audit treatment histories and medical records more precisely, and to bill their patients more accurately, improving payment and hospital operations to the benefit of all concerned. These advancements were already needed before 2020, but proved essential for health care facilities during the COVID-19 pandemic, when they were stretched to the breaking point.

This is why, as discussed above, "use of ADCs has become the standard of care for medication-use process in healthcare systems." Clark, *et al.*, *supra*, at 2283; *accord* Cello, *et al.*, *supra*, at e71. ADCs are, in short, critical to the provision of modern medical treatment and hospital operations.

Further, biometric technology controlling access to ADCs is key to their effectiveness (and thus their utility) because it ensures that ADCs are used securely without being cumbersome. Biometric technology maintains the balance between heath care providers' need for effective medication distribution systems and the equally important need to limit access to controlled substances like opioids—especially in light of the ongoing opioid crisis. Biometric access to ADCs is thus considered a "core" safety process and

best practice in the field. *Guidelines for the Safe Use of Automated Dispensing Cabinets* at 5–6, Inst. for Safe Medication Practices ("ISMP") (2019); *see* Clark *et al.*, *supra*, at 2288.

It is for this reason that the American Society of Health-System Pharmacists recommends that hospital staff be *required*, as a best practice, to use biometrics for accessing ADCs. Cello *et al.*, *supra*, at e73. While lesser technologies for accessing ADCs, including combination codes and passwords, may also be available to health care providers, they are inherently less secure than biometrics because they can be (and have been) shared with others, voluntarily or otherwise. ISMP, *supra*, at 6. And because ADCs are only valuable to health care treatment, payment, and operations if they are effective—and they are only effective if they can be used quickly and securely—the indispensable benefits ADCs bring to the provision of modern health care are tied directly to their use of biometric technology.

II. The legislature did not intend for the absurd and dangerous ends that will likely come from misinterpreting BIPA to hold health care providers liable for using ADCs with biometric security.

When interpreting statutes, this Court presumes that the legislature did not use its lawmaking powers with the intent of achieving absurd ends. *Tims*, 2023 IL 127801, ¶ 22. Yet a decision in this case interpreting BIPA's definition of "biometric identifiers" to include health care providers using ADCs with biometric security will lead to such an absurd end, and with likely devastating

consequences. To understand why that is a fact and not rhetorical hyperbole, it is necessary to first appreciate the state of the health care system in Illinois.

Many Illinois residents suffer from insufficient access to health care services, which is already at crisis levels throughout the state.

There are between 175 and 200 hospitals in Illinois, nearly nine out of ten of which are private institutions, and most of those are non-profits. *See Hospitals by Ownership Type*, Kaiser Family Foundation, *available at* https://www.kff.org/other/state-indicator/hospitals-by-ownership/; *Illinois Hospitals Data Summary - Calendar Year 2019*, Ill. Health Fac. & Serv. Rev. Bd. (2019), *available at* https://hfsrb.illinois.gov/content/dam/soi/en/web/hfsrb/inventories-data/facility-profiles/documents/2019-hospital-state-summary-5-21-21.pdf.[3] Although definitive patient figures for the last several years are not yet available, data predating the COVID-19 pandemic show that Illinois hospitals treated approximately 1.4 million patients on an inpatient basis and 33.2 million patients on an outpatient basis in 2019 alone. *See Illinois Hospitals Data Summary - Calendar Year 2019*, *supra*.

Government-run hospitals in Illinois, which are categorically exempted from BIPA, typically handle only about 4% of inpatient hospital stays. *Hospital Inpatient Days per 1,000 Population by Ownership Type*, Kaiser Family

[3] This figure varies slightly from source to source based on whether one defines the term "hospital" to include institutions such as long-term acute care institutions, psychiatric and rehabilitation institutions, etc.

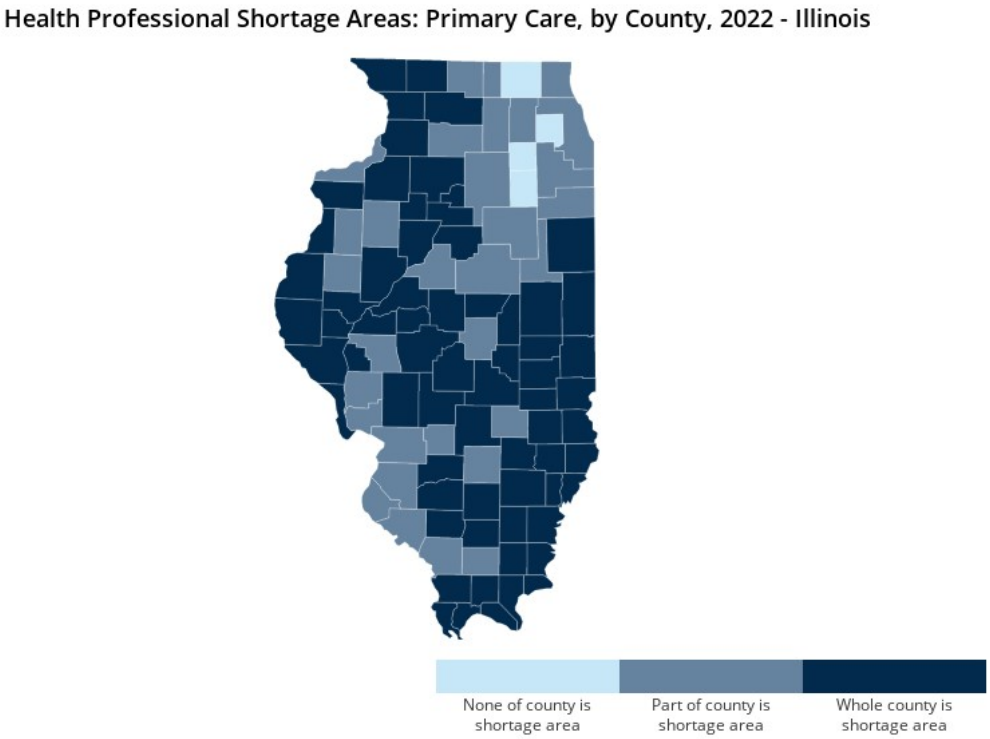
Foundation, *available at* https://www.kff.org/other/state-indicator/inpatient-days-by-ownership; *see* 740 ILCS 14/10. This means that private Illinois hospitals account for 96% of inpatient stays. The ratio is similar (94%) for those patients treated on an outpatient basis. *See Hospital Outpatient Visits per 1,000 Population by Ownership Type*, Kaiser Family Foundation, *available at* https://www.kff.org/other/state-indicator/outpatient-visits-by-ownership.

In addition to the medical services one normally associates with hospitals and other health care facilities, *Amici* and other non-profit entities like them collectively provide nearly *seven billion dollars* each year to Illinois communities and their residents in the form of needed charitable care, uncompensated and unreimbursed care, subsidized health services, community health improvement and health education services, in-kind services, language assistance, sponsorships, and volunteer services. *See Community Benefits*, Ill. Health & Hosp. Ass'n, *available at* https://www.team-iha.org/finance/community-benefits. These community services are vital to the wellbeing of Illinois residents, particularly those who lack adequate access to health care and fall through the proverbial cracks of government programs, such as the indigent, working poor, and immigrants.

The need for such health care services in recent years is greater than it has ever been, and yet the ability of health care providers to deliver it is in a precarious and deteriorating condition. It is no secret that health care facilities emerging from the multi-year state of emergency presented by the COVID-19

pandemic are experiencing record demand for medical care while concurrently facing unprecedented staffing shortages. *See* Neil Steinberg & Ashley Rezin, *'We Nearly Broke the System': Hospitals Face Staff Exodus, Violence Three Years into Pandemic*, Chicago Sun Times (Mar. 24, 2023); Sai Balasubramanian, *The Healthcare Industry Is Crumbling Due to Staffing Shortages*, Forbes (Aug. 26, 2022) (discussing negative effects of staffing shortages on patient care); Steven R. Johnson, *Staff Shortages Choking U.S. Health Care System*, U.S. News & World Report (July 28, 2022) (discussing the growing shortage of health care workers as the nation's "top patient safety concern"); Stacey Hughes, *Challenges Facing America's Health Care Workforce as the U.S. Enters Third Year of COVID-19 Pandemic*, Am. Hosp. Ass'n (Mar. 1, 2022) (letter to Congressional Energy and Commerce Committee describing hospital workforce shortages as a "national emergency").

These problems add to Illinois' already desperate preexisting lack of health care services, particularly in economically depressed urban and rural areas of the state. Large tracts of Illinois are health care deserts. As the map below illustrates, all but four of Illinois' 102 counties are designated by the federal government as partially or fully "medically underserved areas," meaning they lack sufficient numbers of primary care physicians for their population.



Health Professional Shortage Areas, U.S. Health Resources & Serv. Admin. (Nov. 2022), *available at* https://www.ruralhealthinfo.org/charts/5?state=IL. Illinois has 176 medically underserved areas, the third most of any state in the country. *See Health Workforce Shortage Areas*, U.S. Health Resources & Serv. Admin. (Apr. 6, 2023), *available at* https://data.hrsa.gov/topics/health-workforce/shortage-areas.

The problem is acute in rural counties of the state, where the physician-to-patient ratio is half of that in large urban areas. *The State of Rural Health in Illinois: Great Challenges and Path Forward* at 2, Ill. Rural Health Summit Planning Comm. (Oct. 2018) *available at* https://www.siumed.edu/sites/default/files/u9451/rhs_stateofillinois_final1115

.pdf.[4] Rural hospitals are closing at alarming and accelerating rates across the nation. *See Rural Hospital Closures Threaten Access: Solutions to Preserve Care in Local Communities* at 3, Am. Hosp. Ass'n (Sept. 2022), *available at* https://www.aha.org/system/files/media/file/2022/09/rural-hospital-closures-threaten-access-report.pdf. And the sky-high rate of opioid abuse in rural counties, as well as their comparatively older populations, significantly compounds this health care supply and demand problem. *See The State of Rural Health in Illinois*, *supra*, at 3–4. Many of those who most need quality health care in our state do not receive it for lack of access.

This does not mean that urban areas of Illinois are necessarily well off when it comes to access to health care. Even densely populated areas can be health care deserts. Because of the arguably problematic process used by the federal government for designating areas as medically underserved, several poor urban areas—particularly areas with primarily Black residents—have not been officially designated as medically underserved, but have physician-to-patient ratios that are considerably worse than even rural areas of the state. Rob Schroeder, *Medically Underserved Area Designations Missing Low-Income Chicagoans*, Univ. of Ill. Chi. Sch. of Pub. Health (Apr. 26, 2022),

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[4] This tracks national trends. Twenty percent of Americans live in rural areas, while under ten percent of physicians practice in those communities. *Rural Report: Challenges Facing Rural Communities and the Roadmap to Ensure Local Access to High-Quality, Affordable Care* at 5, Am. Hosp. Ass'n (2019), *available at* https://www.aha.org/system/files/2019-02/rural-report-2019.pdf. The problem is even worse when comparing figures concerning the availability of mental health professionals. *Id.*

available at https://publichealth.uic.edu/news-stories/medically-underserved-area-designations-missing-low-income-chicagoans/.

For example, half of all residents of the South Side of Chicago must leave that area to obtain medical care. *Healthcare Transformation Collaboratives* at 3, Ill. Dep't of Healthcare & Family Servs. (Mar. 2021), *available at* https://www2.illinois.gov/hfs/Documents/South%20Side%20Healthy%20Community%20Organization_Application.pdf. This has staggering impacts on almost every field of care, including, by way of example, maternal and infant health. While the causes of geographic disparities are multifactorial, the South Side has lost more than half of its hospitals with obstetrician practices in the last four years. *Id.* at 17. This means that pregnant women there receive nearly one-third fewer prenatal care visits than their North Side counterparts, and the rate of infant mortality incidents is ten times higher than better-resourced areas of the city. *Id.*

There is no shortage of other examples of health outcome disparities, all leading to the same lamentable reality: many people in underprivileged urban and rural areas of the state lack adequate access to medical care and experience unnecessary suffering and needlessly premature mortality as a result.

The legislature could not have intended for BIPA to be read in a way that will exacerbate Illinois' health care crisis.

The Court's decision in this case will go a long way in determining whether the already unfortunate state of access to health care in Illinois

becomes worse. Health care providers, which are under increasing pressure to treat more patients with fewer staff and resources, *must* find and adopt operational efficiencies to avoid falling even further behind the increasing demands placed upon them. Unlike other industries, health care providers cannot simply increase their prices and engage in hiring sprees to respond to market conditions like higher demand, higher operating costs, and inflation.[5] ADCs with biometric security help providers cope with these stresses by—as discussed above—streamlining and making safer the administration of medication. They are crucial to delivering modern health care services.

By the same token, if health care providers are subjected to BIPA's potentially draconian damages regime because they are using much-needed ADCs with biometric security, the results may well be ruinous. Given the prevalence of these devices in Illinois hospitals and other health care facilities, potential cumulative liability across the state could easily reach into the *hundreds of billions of dollars*, dwarfing the market capitalization or other valuations of even the largest hospital systems and providers. This means that Illinois hospitals will inevitably close. Those facilities that survive will have fewer resources for treating patients, and will almost certainly cut back dramatically on patient services along with the important community services

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[5] Rates set by Medicare and insurers are a key driver in health care costs.

discussed above. In other words, the state's already dire health care access problems will get worse—much worse.[6]

This is not what the General Assembly intended when drafting BIPA. There is nothing in BIPA's text or legislative history indicating that lawmakers intended for the protection of biometric information to come before all other interests and considerations, especially the delivery of badly-needed health care services to Illinois residents. It is instead evident that the legislature was balancing several interests when it passed BIPA. This fact is reflected in the statute's text, which specifically excludes from its coverage some activities and sectors deemed so critical as to be beyond its reach, including health care providers in their provision of health care treatment, payment, and operations.

When defining the term "biometric identifier," and thereby defining the very subject of BIPA and its reach, the General Assembly said:

> [b]iometric identifiers do not include [1] information captured from a patient in a health care setting *or* [2] *information collected, used, or stored for health care treatment, payment, or operations* under the federal Health Insurance Portability and Accountability Act of 1996 ["HIPAA"].

740 ILCS 14/10 (emphasis added).[7] This means—in no uncertain terms—that information collected, used, or stored for (1) health care treatment, (2) health

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[6] It is no answer to say that insurance may defray the costs of BIPA liability, as all or nearly all insurance policies now contain BIPA-specific exclusions, and Illinois courts are often reluctant to find coverage in BIPA-related disputes.

[7] This encompasses "biometric information" as well, which BIPA defines as excluding "information derived from items or procedures excluded under the definition of biometric identifiers." 740 ILCS 14/10.

care payment, or (3) health care operations, as those functions are defined under HIPAA, are not biometric identifiers and are consequently exempted from BIPA's requirements. *See also* H.R. 95-276, Gen. Assemb., at 249 (May 30, 2008) (statement by Rep. Ryg that BIPA "provides exemptions as necessary for hospitals").

As the statute's language suggests, these terms are already defined "under" HIPAA to include all the beneficial functions provided by ADCs with biometric security. *See* 45 C.F.R. § 164.501 (defining health care "treatment," "payment," and "operations"). They also have a well-established collective meaning, as the phrase "healthcare treatment, payment, and operations" is used in relevant federal regulations as a recognized term of art. *See Mosby v. Ingalls Mem'l Hosp.*, 2022 IL App (1st) 200822, ¶ 90 (Mikva, J., dissenting). Given this, and because BIPA contains no different or contrary definitions, the relevant statutory language should not be read or redefined in a novel manner, and certainly not in an absurd manner. *See In re Marriage of Lasky*, 176 Ill. 2d 75, 79 (1997) (courts assume the legislature will not draft a new law that contradicts an existing law, and that the legislature intends a consistent body of law when it enacts new legislation).

Amici thus respectfully suggest that the plain and ordinary meaning of this language is subject to only one reasonable and grammatical interpretation, which is reflected in Justice Mikva's dissent below and in

several federal court decisions examining the same language. *See Mosby*, 2022 IL App (1st) 200822, ¶¶ 73–89 (Mikva, J., dissenting); *see also, e.g.*, *Vo v. VSP Retail Dev. Holding, Inc.*, No. 19 C 7187, 2020 WL 1445605, at *2 (N.D. Ill. Mar. 25, 2020).

There is, moreover, no reason to read the relevant statutory text as presenting the Court with the binary choice of either protecting biometric information or entirely exempting the health care industry from BIPA's requirements, as the appellate court majority mistakenly believed. *Mosby*, 2022 IL App (1st) 200822, ¶¶ 64-65. That is a false choice. In plain and ordinary language, the legislature carved out a narrow, but vitally important exception to the definitions of "biometric identifier" and "biometric information" meant to achieve BIPA's primary objective without endangering the viability of Illinois' health care system, and without compromising the wellbeing of the patients and communities our health care providers serve.

To be clear, *Amici* do not argue that the Court should make a policy-based decision about excessive damages and their impact on health care providers. Those decisions are, as this Court recently said, generally best made by the legislature. *Cothron v. White Castle Sys., Inc.*, 2023 IL 128004, ¶ 43. *Amici* rather suggest that the text, legislative history, and canons of statutory construction all point to the same common-sense conclusion: the legislature already made a policy decision.

The General Assembly concluded that "information collected, used, or stored for health care treatment, payment, or operations under [HIPAA]" does not qualify as a biometric identifier or biometric information, and so is not covered by BIPA. This language reflects the obvious. The legislature knew that health care is an essential and complex service. It also knew that health care providers need as many resources and as much flexibility as possible to meet the ever-increasing demand for their essential services. Looking back on the last few years, when health care providers were pushed to the breaking point – at times facing no choice but to render treatment from parking lots, train administrative personnel to help with cleaning functions, stretch a dwindling supply of disposable personal protective equipment, and make heart-wrenching triage choices – the wisdom of that decision is evident and should not be disturbed.

CONCLUSION

When determining the intent behind the statutory language at issue, the Court should ask whether it is reasonable or absurd to conclude that the General Assembly aimed to protect biometric information at the cost of the health and wellbeing of Illinois' residents. When the stakes are this high, and the consequences are this immediate, that question should be understood to answer itself.

WHEREFORE, and for the reasons stated above, *Amici* respectfully request that the Court reverse the decision of the appellate court, and in so

doing find that Section 10 of the Biometric Information Privacy Act, 740 ILCS 14/10, exempts health care providers from BIPA's requirements when collecting, using, or storing health care workers' biometric data for health care treatment, payment, or operations purposes, and for any other relief the Court deems appropriate.

Dated: April 26, 2023

Respectfully submitted,

Advocate Health and Hospitals Corporation, Adventist Midwest Health, Good Samaritan Hospital – Mt. Vernon, Loyola University Health System, Memorial Health System, Northshore University Healthsystem, Rush University System for Health, and St. Mary's Hospital – Centralia, *Amici Curiae*,

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CERTIFICATE OF COMPLIANCE

I certify that this brief conforms to the requirements of Rule 341(a) and (b). The length of this brief, excluding the words contained in the Rule 341(d) cover, the Rule 341(h)(1) table of contents and statement of points and authorities, the Rule 341(c) certificate of compliance, the certificate of service, and those matters to be appended to the brief under Rule 342(a), is 4,559 words.

Dated: April 26, 2023

/s/ *Jonathan B. Amarilio*
Counsel for Amici Curiae

CERTIFICATE OF SERVICE

The undersigned, pursuant to the provisions of 1-109 of the Illinois Code of Civil Procedure, and Ill. S. Ct. R. 12, hereby certifies and affirms that the statements set forth in this instrument are true and correct, except as to matters therein stated to be on information and belief and as to such matters the undersigned certifies as aforesaid that he verily believes the same to be and that he caused the foregoing documents to be sent to the parties listed below on this 26th day of April, 2023, (or upon acceptance of the Court) by *electronic mail* from the offices of Taft Stettinius & Hollister LLP before the hour of 5:00 p.m.:

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