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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

EMBLEMHEALTH, INC., Plaintiff, -against- NORMAN M. ROWE, M.D., NORMAN M. ROWE, M.D. PLLC, NORMAN M. ROWE MD OF NEW JERSEY LLC, ROWE PLASTIC SURGERY OF NEW JERSEY LLC, and EAST COAST PLASTIC SURGERY PLLC PA, Defendants.	Case No. 2:26-cv-3311 (SDW) (MAH)

PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS THE COMPLAINT AND TO STAY DISCOVERY

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PRELIMINARY STATEMENT

In the words of the *New York Times*, "[a] law meant to end surprise medical billing accidentally created a multibillion dollar industry that is making doctors richer."[1] Nobody more so than Dr. Norman Rowe.

This action arises under the explicit terms of the Federal No Surprise Act, 42 U.S.C. § 300gg-111-139 (the "NSA"). The action challenges completely irrational awards Defendants "Rowe" obtained in so-called Independent Dispute Resolution Proceedings ("IDR") by misrepresenting the facts to Independent Dispute Resolution Entities ("IDREs"). To illustrate the complete irrationality, the IDREs awarded up to $440,000 for breast reductions Rowe admit patients ***"can expect to pay on average, anywhere from $15,000 to $25,0000 for."*** (https://normanrowemd.com/how-much-does-breast-reduction-surgery-cost-a-detailed-look/) (emphasis added) (last visited on March 18, 2026.) (Subsequent to the filing of the Complaint, Rowe revised his website to state $18,000 to $28,000.)

Prior to misusing the NSA, Rowe had filed literally hundreds of actions against insurers unsuccessfully demanding exorbitant amounts when their surgical

[1] *See* Sarah Kliff and Margot Sanger-Katz, *A $440,000 Breast Reduction: How Doctors Cashed In on a Consumer Protection Law*, N.Y. Times (Apr. 22, 2026). (A copy of the article is attached to the accompanying Declaration of Juan Olivo, Esq. as **Exhibit "A.**")

mill performed routine breast reduction surgery. In threatening to impose sanctions, Judge McMahon commented on the:

> Numerous cases brought by plastic surgeon Norman Rowe against various insurers [based on] Rowe's exorbitant fees for plastic surgery be performed as an out-of-network provider.

Norman Maurice Rowe, M,D., M.H.A., LLC v. Aetna Life Ins. Co., No. 23-civ-8527, 2025 WL 692051, at *1 (S.D.N.Y. Mar. 3, 2025).

The Emblem insureds Rowe treated were enrolled in the GHI Comprehensive Benefits Plan for City of New York Employees and Retirees (the "NYC PPO Plan"), a PPO with both in and out-of-network benefits. From 2019 thru mid-2021, based upon Dr. Rowe's misrepresentation that he and his colleagues were the only breast surgeons in this geographic area using an allegedly unique short-scar technique, Emblem entered into over one-hundred and fifty (150) Single Case Agreements ("SCAs")[2] with Rowe. In the SCAs, Emblem agreed to pay, and Rowe agreed to accept, $25,500 for the primary surgeon and $4,080[3] for the assistant surgeon (if

[2] A Single Case Agreement (SCAs) is a one-time, patient specific settlement agreement negotiated between Emblem and an out-of-network provider for a specific service. SCAs are used in situations where, for example, there is no in-network provider who can perform the services at issue, or an out-of-network provider has a special expertise. In a SCA, Emblem and the out-of-network provider agree in advance on the fee that will be paid in lieu of the Plan's benefit amount, and the provider further agrees not to balance bill the patient.

[3] The $4,080 represented 16% of the primary surgeon's amount, which is the Medicare guideline under Section 1848(i)(2)(B) of the Social Security Act.

needed) for a breast reduction in lieu of the NYC PPO Plan benefit amount. Emblem stopped entering into SCA's with Rowe, however, when in mid-2021 Rowe was unable to substantiate that they were the only provider using this purported "unique" technique, which they were not. Thereafter, in hundreds of breast reductions, Rowe accepted the NYC PPO Plan benefit amount for an out-of-network provider, which was between $6,000 and $10,000. Rowe did not (and does not) balance bill patients for the difference between their fictitious "billable charge" and the benefit amount paid under the NYC PPO Plan.

This all changed after Congress enacted the NSA. The NSA was intended to address "surprise bills" and reduce the healthcare costs from out-of-network providers. One example is when a patient is suffering from a medical emergency and receives treatment at the emergency room, where the on-call physician may not be in the patient's health care network. Another example is when an out-of-network provider renders services to a patient at an in-network hospital, and the patient "unknowingly" receives treatment from an ancillary provider who is out-of-network, like the anesthesiologist or radiologist. *See* H.R. Rep. 116-615, at 51. (The IDREs and courts have not limited application of the NSA in this situation to cases where the services were unknowingly provided by the out-of-network provider.) Rowe could have scheduled the breast reductions at one of the many out-of-network surgical facilities they had access to in New York and New Jersey, including Dr.

Rowe's own facility. They instead scheduled the procedures at an in-network hospital, notwithstanding that Rowe's website states that this will increase the cost of the procedure, so they could misuse the NSA. (Compl. ¶ 24 (citing https://normanrowemd.com/how-much-does-breast-reduction-surgery-cost-a-detailed-look/).)

Rowe billed the patients (and Emblem) up to an astounding $600,000 for a routine breast reduction. After being paid the applicable benefit amount under the NYC PPO Plan, Rowe commenced IDR Proceedings under the NSA. Those proceedings included *ex parte* submissions, including an offer, by each side to the IDREs. The IDREs then selected one of the two offers. Although Emblem did not receive Rowe's *ex parte* submissions, based upon the IDREs' decisions, Rowe plainly submitted false, misleading, incomplete and knowingly inaccurate information to the IDREs. The IDREs awarded completely irrational amounts as high as $440,000 for a procedure Rowe admits costs between $15,000 and $25,000.

The impact of these obscene awards will be borne by the hundreds of thousands of New York City employees and retirees enrolled in the NYC PPO Plan, whose premiums will increase as a result. As discussed below, Rowe's Motion should be denied because:

First, the Court has subject matter jurisdiction because this action arises under the clear and unambiguous provisions in the NSA. *See* 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I)&(II).

Second, Rowe's Motion fails to address the First Cause of Action, and that the NSA explicitly provides that a determination by an IDRE "shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity involved regarding such claim . . ." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I). If binding in the absence of misrepresentation of the facts to the IDR entity, then an award is necessarily not binding where the facts were misrepresented. Any other construction would render Section (c)(5)(E)(i)(I) meaningless. *See Pulsiver v. United States*, 601 U.S. 124, 143, (2024) ("When a statutory construction 'render[s] an entire subparagraph meaningless' . . . the canon against surplusage applies with special force.") (*quoting Nat'l Ass'n of Mfrs. v. Dep't of Def.*, 583 U.S. 109, 128, (2018).) A non-binding arbitration award has no force of law and can neither be confirmed nor vacated.

Third, the Complaint's Second Cause of Action alternatively alleges that the IDRE awards are subject to vacatur on multiple grounds under the NSA, which incorporates Section 10(a) of the Federal Arbitration Act ("FAA"). Rowe's Motion studiously ignores the allegations in the Complaint (and the caselaw) holding that an arbitration award may be vacated when it is completely irrational. *See Swift Indus.*

Inc. v. Botany Indus., Inc., 466 F. 2d 1125, 1130 (3d Cir. 1972). Rowe's Motion similarly fails to address the Second Cause of Action's allegations seeking vacatur on grounds that the awards also violate public policy.

With respect to the only ground for vacatur they do address – fraud – Rowe argues the Complaint fails to satisfy Rule 9(b). They are wrong; at least ten separate misrepresentations are pled. Moreover, where the facts are within the exclusive possession of the party who made the misrepresentations, as they are here, the standard under Rule 9(b) is relaxed. The Complaint's allegations clearly provide Rowe with notice of the claims against them.

Finally, the state law causes of action, over which the Court has supplemental jurisdiction, are not preempted and state causes of action as demonstrated below.

STATEMENT OF FACTS

The following facts must be accepted as true for purposes of this Motion.

A. Rowe: Dr. Rowe provides plastic surgery services, including breast reductions, to patients in New York, New Jersey and Florida. Dr. Rowe owns, manages, operates and controls each of the Defendants, and employs at least three other surgeons who perform hundreds of breast reductions per year. (Compl. ¶¶ 21-22.) Rowe's billboards appear on major highways and roads throughout New York and New Jersey, claiming that "Breast Reduction [is] COVERED BY INSURANCE." (Compl. ¶ 23.)

As Dr. Rowe states on YouTube, breast reduction surgery is a "very common" and "routine" procedure, representing "one of the top ten procedures performed by plastic surgeons in the United States." (Compl. ¶ 24.) Rowe also informs prospective patients that having a breast reduction done in an ambulatory surgery center minimizes the fees because "[h]ospitals usually charge more if you have to use them." (*Id*. ¶ 24.)

B. Rowe Unnecessarily Schedules Reductions At In-Network Hospitals: If Rowe performed reductions at an out-of-network ASC, including their own fully accredited operating room, the procedures would not be eligible for the NSA's IDR process. Notwithstanding that the cost will be higher, by pre-scheduling routine breast reductions at an in-network hospital, Rowe manufactures a basis to access the NSA's IDR process. (*Id*. ¶¶ 25-30.)

C. The NYC PPO Plan: The awards at issue all concern NYC PPO Plan members. The NYC PPO Plan provides both in-network and out-of-network benefits to New York City employees, retirees and their dependents at rates critical to maintaining affordable premiums for NYC PPO Plan members. (*Id*. ¶ 33.) The out-of-network benefit varies depending on whether the insured is covered by certain riders and their applicable deductible and copayment. The benefit for a bilateral breast reduction performed by an out-of-network provider is under $10,000. (*Id*. ¶ 34.) When NYC PPO Plan members pre-schedule breast reduction surgeries with

Rowe, both Rowe and the member know the amount of benefits that will be reimbursed to the plan member (and paid to Rowe). This allows NYC PPO Plan members to decide whether to have the surgery performed by Rowe instead of by one of the numerous in-network plastic surgeons. (*Id.* ¶ 35.)

D. The NSA Was Enacted To Curb Abusive Billing Practices By Out-Of-Network Providers: Health plans contract with a network of health care providers from whom their members may obtain "in-network" care. Such contracts govern the rate for the services and prohibit the participating providers from balance billing the patients directly for the difference between the contract rate and their billable charges. Generally, patients receive more affordable health care coverage when receiving treatment from in-network providers. (*Id.* ¶ 37.) Enrollees in the NYC PPO Plan can also obtain treatment from out-of-network providers. Because out-of-network providers are not bound by contractual billing limitations, patients typically pay more when they elect to receive care from out-of-network providers. (*Id.* ¶ 38.)

There are situations in which a patient has no ability to choose between in- and out-of-network care. One example is when the patient receives treatment in the emergency room, where the on-call physician may not be in the patient's health plan's network. (*Id.* ¶ 39.) Another example is when a patient visits an in-network hospital but ***"unknowingly"*** also receives services from an out-of-network physician, such as an anesthesiologist, radiologist or some other ancillary service provider. H.R. Rep. 116-615,

at 51. In these "[s]ituations . . . [the] patients have little or no control over whether a provider is in or out-of-network [.]" (*Id.*; Compl. ¶ 40.) Prior to the enactment of the NSA, surprise billing providers were able to "charge amounts for their services that ... result[ed] in compensation far above what is needed to sustain their practice" because patients lacked the ability "to meaningfully choose or refuse care." (H.R. Rep. No. 116-615 at 53; Compl. ¶ 43.) Surprise billing providers reaped massive profits by issuing surprise medical bills to patients and had little incentive to contract with health plans to offer more affordable health care services to American consumers. (Compl. ¶ 44.) This "market failure" was having "devastating financial impacts on Americans and their ability to afford needed health care." (H.R. Rep. No. 116-615 at 52; Compl. ¶ 45.) In response, Congress enacted the NSA to ensure that patients shall bear no more financial obligation to an out-of-network provider for a "surprise" bill than the patient would if the service had been rendered by an in-network provider. (Compl.¶ 48.)

Congress also provided a mechanism for patients and out-of-network providers to opt out of the NSA where the patient knowingly elects to receive non-emergency services from an out-of-network provider. (*Id.* ¶¶ 50-52.) Section 132(d) provides that the provider can provide the patient, at least 72 hours in advance of the date on which the non-emergency services are rendered, a copy of a written Notice and Consent Form under which the patient can waive the NSA. (*Id.* ¶ 52.) Rowe could have obtained a signed NSA Notice and Consent Form from every Emblem member on

whom they performed a breast reduction. Because doing so would have prevented Rowe from pursuing their fraudulent scheme, Rowe either did not provide the form to the patients or mislead the patients not to sign it by failing to inform them that Rowe had no intention of balance billing them. (*Id.* ¶ 53.)

E. The IDR Process: When a health plan receives a claim for out-of-network services subject to the NSA, it must make an initial payment or issue a notice of denial of payment within 30 days. *See* 42 U.S.C. § 300gg-111(a)(1)(C)(iv)(I). (Compl. ¶ 56.) If the provider is dissatisfied with the initial payment, it may initiate open negotiations with the health plan within thirty (30) business days of the initial payment or notice of denial. 42 U.S.C. § 300gg-111(c)(1)(A). After initiating open negotiations, the provider must attempt in good faith to negotiate a resolution with the health plan during the open negotiation period. (Compl. ¶¶ 57-58*)* If "the open negotiations . . . do not result in a determination of an amount of payment for [the] item or service," and the patient did not opt out of the NSA's balance billing protections pursuant to the NSA Notice and Consent Form, the provider may initiate the IDR process through a Federal website called the IDR Portal. *See* 42 U.S.C. § 300gg-111(c)(1)(B); 45 C.F.R. § 149.510(b)(2)(i). (Compl. ¶¶ 59-63.)

After the IDR process is initiated, the parties select, or HHS appoints, an IDRE. 42 U.S.C. § 300gg-111(c)(4)(F). IDREs are private entities who apply to become certified to conduct IDR Proceedings. (Compl. ¶¶ 65-67.) The provider and

health plan then each submit an offer, along with supporting information, and the IDRE selects one party's offer as the out-of-network rate. (*Id.* ¶ 68.) 42 U.S.C. § 300gg-111(c)(5)(B).) The submissions to the IDRE are made on an *ex parte* basis so that neither side sees the other side's submission, much less has the opportunity to rebut or address any misleading or inaccurate information therein. As such, it is a process literally rife for fraud. (Compl. ¶ 69.)

F. The NSA Was Established To Achieve Reasonable Compensation Roughly Approximating Average In-Network Rates: To fully drive home its goal to curb out-of-network providers' inflated "billed charges, the NSA states that a provider's "billed charge" may not be considered by an IDRE. 42 U.S.C. § 300gg-111(c)(5)(D). (Compl. ¶ 70.) Rather, the NSA and its implementing Rules limit the IDRE's consideration to the so-called Qualifying Payment Amount ("QPA") and five additional considerations: (a) the provider's level of training, experience and quality outcomes measurements, (b) the provider's market share, (c) patient acuity, (d) the provider's teaching status, case mix and scope of services, and (e) any demonstrations of good faith efforts (or lack thereof) by the provider to enter into a network agreement with the private insurer. (Compl. ¶¶ 70-71.) The QPA is roughly the median rates that the insurer is paying in-network providers for the same services in the same geographic area. (*Id.* ¶ 65.)

It was Congress' "intent and . . . determination that the QPA, which reflects standard market rates arrived at through private contract negotiations, represents a reasonable rate for services in a vast majority of cases," and should "serve as a predominate data point for the IDR entity to consider." *See* October 20, 2021 Letter from Frank Pallone, Jr.; available at: Pallone Murray No Surprises Act IFR Comment Ltr 10.20.212.pdf. (Compl.¶ 72.)

Not less than thirty (30) business days after selection, the IDRE must choose the offer it determines "best represents the value of the qualified IDR item or service as the out-of-network rate." 45 CFR 149.510(c)(4)(ii)(A). The IDRE must "explain its determination in a written decision," including "what information the certified IDR entity determined demonstrated that the offer selected . . . is the offer that best represents the value of the . . . service, among other things. (Compl. ¶ 75.) In practice, IDREs issue decisions made by unidentified person(s) that, for the most part, contain little explanation. (*Id.* ¶ 76.)

G. Rowe Has Systematically Abused The NSA's IDR Process: Rowe engages in the fraudulent practice of "fee forgiving" by intentionally waiving and/or failing to attempt to collect the balance due from patients they treat. *Feiler v. N.J. Dental Ass'n*, 191 N.J. Super. 426, 437-39 (Sup. Ct. 1983), *aff'd,* 199 N.J. Sup 363 (App. Div. 1984); *Nutrishare, Inc. v. Conn. Gen. Life Ins. Co.*, 2024 WL 1028351, at *6 (E.D. Ca. Mar. 13, 2014); *Conn. Gen. Life Ins. Co. v. True View Surgery Center One,*

L.P., 128 F. Supp. 3d 501, 506 (D. Conn. 2015). Fee forgiving drives up medical costs because, among other things, it diminishes the patient's incentive to seek treatment from in-network providers. (Compl. ¶¶ 99-100.) One of the reasons Rowe does not pursue the balance is because their billable charge is a fictitious amount they never had any intention of pursuing, let alone collecting. (*Id.* ¶ 101.)

To illustrate that Rowe's billable charge is fictitious, in 2020 and part of 2021, Rowe and Emblem entered into over one-hundred and fifty (150) SCAs in which Rowe agreed to accept $25,500 for the primary surgeon and $4,080 for the assistant surgeon for a breast reduction performed on NYC PPO Plan members. (*Id.* ¶¶ 101-102.) When no SCA was entered into, both prior to 2020 and subsequent to mid-2021, Rowe accepted the applicable out-of-network benefits in hundreds of breast reductions performed on NYC PPO Plan members. (*Id.* ¶ 105.) This all changed, however, when Rowe figured out they could misuse the NSA to fraudulently obtain completely irrational awards. (*Id.* ¶ 106.)

The NSA's IDR process is astonishingly opaque. It does not include any procedures to view, verify or rebut the opposing party's *ex parte* submission. (*Id.* ¶¶ 107-108.) There is no discovery, testimony or cross-examination, and no hearing. Although Emblem did not receive any of the information Rowe submitted to the IDREs, the awards indicate that Rowe submitted falsified, inaccurate and materially misleading information. (*Id.* ¶¶ 109-115.) To obtain even higher awards, Rowe

doubled their fictitious billable charge for the primary surgeon from $150,000 to $300,000, and increased the billable charge for the assistant surgeon from $45,000 to the same $300,000. (*Id.* ¶ 117.).

Rowe are currently billing $600,000 and securing IDR awards totaling $440,000 for a breast reduction procedure in which the QPA is below $10,000, for which Rowe has historically been paid and accepted from $6,000 to $30,000 in hundreds of surgeries performed on NYC PPO Plan members, and which Rowe admits should cost from $15,000 to $25,000. (*Id.* ¶¶ 118.)

MOTION TO DISMISS STANDARD

"When deciding a motion Rule 12(b)(6), courts 'must accept all factual allegations in the complaint as true, construe the complaint in the light favorable to the plaintiff,' and determine 'whether [the] plaintiff may be entitled to relief under any reasonable reading of the complaint.'" *Edmond v. State*, 2026 WL 194495, at *2 (D.N.J. Jan. 26, 2026) (Wigenton, U.S.D.J.); *see Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009).

"A defendant may move to dismiss a complaint for lack of subject-matter jurisdiction under Fed. R. Civ. P. 12(b)(1) by challenging jurisdiction facially or factually." *Lopez v. Law Offices of Faloni & Assocs., LLC*, 2017 WL 2399083, at *1 (D.N.J. June 2, 2017) (Wigenton, U.S.D.J.) (*citing Constitution Party of Pennsylvania v. Aichele*, 757 F.3d 347, 357 (3d Cir. 2014)). "A facial challenge to

subject-matter jurisdiction 'considers a claim on its face and asserts that it is insufficient to invoke the subject-matter jurisdiction of the court because, for example, it does not present a question of federal law ....'" *Id*. (quoting *Aichele*, 757 F.3d at 358). "In contrast, a factual challenge 'is an argument that there is no subject matter jurisdiction because the facts of the case . . . do not support the asserted jurisdiction.'" *Id*. "Drawing this distinction is important because it 'determines how the pleading must be reviewed.'" *Id.* (*quoting Aichele*, 757 F.3d at 357–58). *See also In re Schering Plough Corp. Intron/Temodar Consumer Class Action*, 678 F.3d 235, 243 (3d Cir. 2012). Where, as here, a motion for lack of subject matter is made prior to the defendant's service of an answer, it is a facial challenge. *Aichele*, 757 F.3d at 358. "[A] a facial attack calls for a district court to apply the same standard of review it would use in considering a motion to dismiss under Rule 12(b)(6), i.e., construing the alleged facts in favor of the nonmoving party." *Id.*.

I. THE COURT HAS SUBJECT MATTER JURISDICTION

Section (c)(5)(E)(i)(I) provides, in pertinent part, that: "A determination of a certified IDR entity . . . . (I) shall be binding upon the parties involved, ***in the absence of*** a fraudulent claim or evidence of misrepresentation of facts present to the IDR entity involved regarding such claim . . ." 42 U.S.C. § 300gg-111(c)(5)(E)(i)(I) (emphasis added). Because Section (c)(5)(E)(i)(I) expressly states that fraudulently-procured IDR awards are not binding, the First Cause of Action

seeks a declaration that the awards here are not binding on Emblem. This raises a federal question under Section (c)(5)(E)(i)(I). In the alternative, if the awards are binding, the Second Cause of Action seeks to vacate the awards pursuant to Section (c)(5)(E)(i)(II) on multiple grounds. These allegations, too, raise a federal question.

Rowe argues "[t]he [NSA] does not say that an application to vacate may be brought in a federal court" and does not create a private right. (Memorandum of Law in Support of Defendants' Motion to Dismiss the Complaint ("Moving Memo") at 8.) Rowe is conflating cases holding that there is no private right of action to ***confirm*** an IDR award (*see* Moving Memo at 9 n.6) with the causes of action here. Numerous courts have observed that Congress intentionally opted to provide a private right of action only to vacate an IDR award.

For example, in *Modern Orthopaedics of NJ v. Premera Blue Cross,* 2025 WL 3063648 (D.N.J. Nov. 3, 2025), Judge Martinotti observed that "The only role contemplated for the federal courts in the NSA is the ability to *vacate* an award" on any of the grounds set forth in Section 10(a) of the FAA. (*Id.* at *8) (emphasis added). Similarly, in *Specialtycare Inc. v. Aetna, Inc.*, 2025 WL 3719227 (M.D. Pa. Dec. 23, 2025), the Court explained: "Notably, while the NSA does not create an explicit cause of action to *confirm* an IDR award, it does create a cause of action to *vacate* one." 2025 WL 3719227, at *2 (emphasis in original). *See Neuroshield Network SE, LLC v. S&S Healthcare Strategies*, 2026 WL 743000 at *5 (N.D. Ga.

Mar. 16, 2026); *Worldwide Aircraft Servs. Inc. v. Freedom Life Ins. Co. Am.*, No. 25-cv-1158, 2025 WL 3551397, at *2 (M.D. Fla. Dec. 11, 2025). Rowe's argument that the court lacks subject matter jurisdiction is just plain wrong.

Rowe further argues that "[t]he language of [Section (c)(5)(E)(i)(II) of the NSA], instead of creating a private right of action, merely creates a procedure by which a party can make an application for a summary proceeding to vacate an arbitral award." (Moving Memo. at 8.) The two cases Rowe relies upon do not support this argument. *Teamsters Loc. 177 v. United Parcel Serv.*, 966 F.3d 245, 248 (3d Cir. 2020), did not involve vacatur of an IDR award and says nothing about whether the NSA creates a private right of action to vacate an award in federal court. The court explained there that an action to *confirm* an arbitral award would properly be brought through a summary proceeding, because there is nothing to do in such an action other than to confirm the award. *Id.* at 248. The same is not true for an action to vacate an award.

Rowe cites *Goldman v. Citigroup Glob. Market Inc.*, 834 F.3d 242, 249 (3d Cir. 2016), for the proposition that "The FAA does not itself provide a federal cause of action for vacatur of an arbitration award." (Moving Memo. at 8.) This is a strawman because Emblem is not relying upon the FAA for jurisdiction. Similarly, *Badgerow v. Walters*, 596 U.S. 1, 8 (2022), merely stands for the proposition that Section 10(a) of the FAA "do[es] not [itself] support federal jurisdiction." The First

and Second Causes of Action are, however, premised on Sections (c)(5)(E)(i)(I) and (II) of the NSA, and not on Section 10(a) of the FAA. Rowe's alternative argument, that "[t]he Declaratory Judgment Act . . . alone does not provide a court with jurisdiction," fails for the same reason. (Moving Memo. at 10 n.7.) Emblem premises jurisdiction on the NSA, and not on the Declaratory Judgment Act.

Finally, Rowe's position is irreconcilably at odds with the position they have taken in dozens of actions they have commenced in this District and other federal courts purportedly invoking federal jurisdiction to confirm IDR awards under the NSA. *See, e.g.*, Stay and Administrative Termination Order dated January 16, 2026 entered by Chief Judge Renée Marie Bumb in *In re No Surprises Act Cases*, 2:25-cv-14860 (ES) (SDA) ("*Administrative Stay Order*") at Schedule A (listing at least forty (40) cases commenced by Rowe in this District alone).

II. ROWE'S MOTION TO DISMISS COUNT I SHOULD BE DENIED

Rowe's Motion does not address Count I, except to mistakenly argue that the Court lacks subject matter jurisdiction to address it. Because the Court possesses jurisdiction and Rowe makes no other argument, Rowe's motion to dismiss Count I should be denied. *See K.S.D. v. Ryan*, 2024 WL 180798, at *9 (D.N.J. Jan. 17, 2024) (denying motion to dismiss as to cause of action movant failed to address); *Jordan v. N.J. Dep. of Corrections*, 881 F. Supp. 947, 950 n.2 (D.N.J. 1995).

The foregoing aside, Section (c)(5)(E)(i)(I) explicitly provides that a determination by an IDRE "shall be binding upon the parties involved, in the absence of a fraudulent claim or evidence of misrepresentation of facts . . . to the IDR entity." It is black-letter law that a statute should not be interpreted to "render[s] an entire subparagraph meaningless." *Pulsiver v. United States*, 601 U.S. 124, 143 (2024); *see United States v. Milchin*, 128 F. 4th 199, 202 (3d Cir. 2025). "The canon again surplusage counsels . . . to give effect to every word of a statue." *Paek v. Atty Gen.*, 793 F. 3d 330, 337 (3d Cir. 2015).

If an IDR award is binding in the absence of misrepresentation of the facts to the IDRE, then it necessarily follows that an award is not binding where the facts were misrepresented. Otherwise, the language in Section (c)(5)(E)(i)(I) is meaningless surplusage, inserted by Congress for no reason and serving no purpose. Respectfully, it is not for the courts to ignore Congress' determination that awards obtained by misrepresentation of facts to an IDRE are not binding. In fact, non-binding arbitration awards are not reviewable. *See Dluhos v. Strasberg,* 321 F.3d 365, 370 (3d Cir. 2003). If an award is not binding, it has no legal force and can neither be confirmed nor vacated. *See id.; Twp. of Bordentown, NJ v. Fed. Energy Regul. Comm'n*, 903 F.3d 234, 262 n.16 (3d Cir. 2018) ("We discern no meaning to the word 'binding' other than 'having legal force to impose an obligation'") (*quoting* Black's Law Dictionary (10th ed. 2014)). The decision in *Med-Trans Corp. v. Cap.*

Health Plan, Inc., 700 F. Supp. 3d 1076, 1086 (M.D. Fla. 2023), *aff'd sub nom. Reach Air Servs. LLC v. Kaiser Found. Health Plan, Inc.*, 160 F.4th 1110 (11th Cir. 2025), that Section (c)(5)(E)(i)(I) should not be applied because it "provides no information on how to bring an action . . . or what the standards would be" ignores well-settled rules of statutory construction and an entire section Congress included in the NSA. Respectfully it was wrongly decided.

Emblem argues that the awards are not binding because they were based on misrepresentation of the facts to the IDREs. (Compl. ¶¶ 377-81.) Rowe disagrees. Accordingly, Emblem properly seeks judgment declaring the awards are not binding.

Given Rowe's argument that awards procured by misrepresenting facts to an IDRE are not subject to vacatur on that ground, a determination that such awards are not binding in accordance with the unambiguous language of Section (c)(5)(E)(i)(I), is the only way to avoid opening the door to massive fraud in IDR proceedings.

III. THE SECOND CAUSE OF ACTION SHOULD NOT BE DISMISSED

The sole question is whether Emblem has alleged facts that, assuming they are true, state a cause of action to vacate the awards under the NSA. The answer is a resounding yes.

A. The Complaint Alleges The Awards Are Completely Irrational

Rowe's Motion fails to address that the Complaint repeatedly alleges that vacatur is warranted on the grounds that the awards are "completely irrational." In

Swift Indus., Inc. v. Botany Indus., Inc., 466 F.2d 1125 (3d Cir. 1972), the Third Circuit held that a commercial arbitration "award may not stand if it does not meet the test of fundamental rationality." (*Id* at 1131.) Discussing their decision in *Ludwig Hanold Mfg. Co. v. Fletcher*, 405 F. 2d 1123 (3d Cir. 1969), the Court held that (*Swift Indus.*, 466 F.2d at 1331):

> *Honold* has, in addition to limiting the arbitrator's authority to fashion relief, also established that an award may not stand if it does not meet the test of fundamental rationality. The New York Court of Appeals, whose opinions are the source of much instruction in this field, has held that an award of an arbitrator is not subject to judicial revision unless it is "completely irrational," Lentine v. Fundaro, 29 N.Y.2d 382, 328 N.Y.S.2d 418, 278 N.E.2d 633 (1972). We consider this formulation to be a fair rendering of *Honold.* In any event, it is an accurate statement of the law.

Affirming the district court's vacatur of the arbitrator's award, which provided for payment of $6 million cash or a surety bond, the Third Circuit held the award was "completely irrational because a $6 million cash bond could not be deemed rational in view of Botany's maximum $1.5 million liability. (*Id.* at 1134.) *See Verizon Pennsylvania, LLC v. Commc'ns Workers of Am., AFL-CIO, Loc 13000*, 13 F.4th 300 (3d Cir. 2021) (vacating award as irrational); *PMA Cap. Ins. Co. v. Platinum Underwriters Bermuda, Ltd.*, 659 F. Supp. 2d 631, 638-39 (E.D. Pa. 2009) (citing *Swift* and vacating award pursuant to Section 10(a)(4) of the FAA where it was completely irrational.)

The words in *Swift* could have been written for this action. An award of $440,000 does not meet the test of fundamental rationality. Indeed, an award of $440,000 for a $15,000 to $25,000 procedure is less rational than a $6 million bond for a $1.5 million liability. The amount awarded is approximately 1,760% to 3,000% of the amount Rowe admits the procedure costs. The awards wildly exceed the cost of a breast reduction throughout the United States, including in New York and New Jersey. (*See* the accompanying Declaration of Dr. Arthur Perry dated June 18, 2026.)

The NYC PPO Plan provides coverage to hundreds of thousands of New York City employees and retirees, at affordable premiums that are largely based upon the cost of healthcare provided to NYC PPO Plan members. If completely irrational awards cannot be reviewed by a Federal court, there is nothing to prevent Rowe and other out-of-network providers from continuing to fraudulently procure wildly irrational awards. The increased costs of these awards will be borne by the very people the NSA was supposed to protect, NYC PPO Plan members.

B. <u>The Awards Violate Public Policy</u>

A court may also vacate an arbitration award that violates a "well defined and dominant" public policy, ascertained "by reference to the laws and legal precedents and not from general consideration of supposed public interests." *W.R. Grace & Co. v. Loc. Union 759, Int'l. Union of United Rubber, Cork, Linoleum & Plastic Workers of Am.,* 461 U.S. 757 (1983). In *Stroehmann Bakeries, Inc. v. Loc. 776, Int'l. Bhd.*

of Teamsters, 969 F. 2d 1436 (3d Cir. 1992), the Third Circuit affirmed the district court's vacatur of an award reinstating an employee accused of sexual harassment without a determination as to whether or not the harassment had actually occurred. The award was vacated because it conflicted with the public policy against workplace sexual harassment, as expressed in Title VII and related legal precedents. *Id.* at 1441-42. *See Welch Foods, Inc. v. Gen. Teamsters, Loc. Union No. 397*, 2025 WL 1912352 (3d Cir. July 11, 2025); *Exxon Shipping Co. v. Exxon Seamen's Union*, 11 F. 3d 1189 (3d Cir. 1993).

In enacting the NSA, Congress expressed the strong public policy that the statute and IDR process were being adopted to decrease the cost of healthcare services provided by out-of-network providers. *See T.V. Seshan, M.D., PC v. Aetna, Inc.*, 2026 WL 867151, *1 (S.D.N.Y. Mar. 20, 2026) (noting that the NSA "set out accomplishing twin aims: protecting patients from unexpected, financially ruinous medical bills, and curtailing the rising costs of out-of-network treatment") (citing Letter from Frank Pallone and Patty Murray to Departments). The awards here do just the opposite. If Rowe were paid $440,000 for every breast reduction they perform, we conservatively estimate that the annual cost would exceed $120 million. (Compl. ¶ 14.) These elective procedures were prescheduled months in advance at an in-network hospital so Rowe could mislead an IDRE to award an irrational fee that bears no relationship to the cost or value of the services provided – something

the courts had refused to do in hundreds of unsuccessful actions Rowe filed. This flies-in-the face of the very policy that led to passage of the NSA.

C. The Awards Were Procured By Fraud

The Complaint alleges in detail the numerous misrepresentations Rowe made to the IDREs, including that: (i) Rowe was the "only physician" in his "small private practice" (Compl. ¶ 143); (ii) Emblem had refused to enter into Single Case Agreements (*Id.* ¶ 152) ; (iii) Emblem had refused to engage in good faith efforts to negotiate a settlement (*Id.*); (iv) Rowe had "completed extensive research, numerous publications, and presentations" (*Id.* ¶¶ 154, 217); (v) Rowe had attempted in good faith to negotiate an agreement to become an in-network provider with Emblem (*Id.* ¶¶ 156, 185); (vi) Rowe's services were "unique" (*Id.* ¶¶ 182, 186, 219, 245); (vii) Rowe's contractual history with Emblem, including the previous 4 plan years, showed that the rate of payment he had received was "closer to [Rowe's] offer in this case" (*Id.* ¶¶ 242-243, 280-81); and (viii) Rowe's billable charge was from $194,628 to $300,000 for the primary surgeon, and the same amount for the assistant surgeon. (*Id.* ¶¶ 238, 255, 318). None of these representations were true. (*Id.* ¶¶ 144-57; 185-88; 216-21; 242-51; 281-86; 344-54.)

Rowe argues that Emblem cannot allege fraud with particularity because "it has never actually seen" what they submitted to the IDRE on an *ex parte* basis. (Moving Memo. at 13.) This argument fails. First, the IDREs indicated they were

relying on specific factual representations made by Rowe that were patently false and misleading. Second, where the factual information concerning the misrepresentations "is peculiarly within the defendant's knowledge or control," the requirements of Rule 9(b) are relaxed. *In re Rockefeller Propes. Inc. Sec. Litig.*, 311 F. 3d 198, 216 (3d Cir. 2002); *see Nype v. Sam*, 2024 WL 129803 (D.N.J. Jan. 11, 2014). Courts should apply Rule 9(b) "with some flexibility and should not require plaintiffs to plead issues that may have been concealed by the defendants." *Gelis v. Bayerische Motoren Werke Aktiengesellschaft* 2018 WL 6804506 at *2 (D.N.J. Oct. 30, 2018). "The central inquiry . . .is whether the complaint is sufficiently precise to place the defendant on notice." *Kaiser Found. Health Plan, Inc. v. Medquist, Inc.*, 2009 WL 961426 at *6 (D.N.J. Apr. 8, 2009).

The Complaint's allegations clearly put Rowe on notice. Indeed, Rowe does not argue otherwise. If Rowe were right that Emblem cannot satisfy Rule 9(b) by alleging the fraudulent misrepresentations recited by the IDREs in their decisions, then no party could ever challenge an IDR award on grounds of fraud because the submissions to the IDRE are *ex parte*.

Rowe incorrectly argues that Emblem could have raised the allegations of fraud during the IDR proceedings. (Moving Memo at 11.) Stated otherwise, Rowe accuses Emblem on the one hand of alleging fraud "entirely on supposition" . . . "based on submissions that it has never actually seen" (Moving Memo at 13), and

then argues on the other hand that Emblem actually knew all about the fraud and could have raised it in the IDR proceeding. The court should not countenance this "heads I win, tails you lose" argument.

Rowe also argues that "bad faith . . .such as bribery, undisclosed bias of an arbitrator, or willfully destroying or withholding evidence" must be alleged to vacate an IDR award under the NSA, and that defrauding the IDRE is not sufficient. (Moving Memo at 14.) As discussed above, this argument reads Section (c)(5)(E)(i)(I) out of the NSA. Further, the Complaint does plead bath faith, including that Rowe both misrepresented the facts to the IDREs and withheld evidence. To the extent Rowe argues they were free to lie to the IDRE's, or withhold important information, they are wrong. The parties to an IDR proceeding must certify that the information they submit is accurate, true, and not false or fraudulent. *See* http://nsa-idr.cms.gov/paymentdisputes/s/. Lying under oath or knowingly concealing evidence constitutes fraud under Section 10(a)(1) of the FAA. *France v. Bernstein*, 43 F.4th 367, 378 (3d Cir. 2022).

The decisions Rowe relies upon are inapposite. *Guardian Flight, L.L.C. v. Med. Evaluators of Tex., ASO, L.L.C.*, 140 F.4th 613 (5th Cir. 2025), did not address and is inconsistent with Third Circuit precedent recognizing that an award can be vacated under the NSA where it is entirely irrational and violates public policy. Furthermore, *Guardian Flight* read NSA Section (c)(5)(E)(i)(I) entirely out

of the statute altogether. The two district court decisions Rowe cites also did not address whether an IDR award could be vacated because it was completely irrational or violated public policy, or whether an award that was based on misrepresentation of the facts to an IDRE was, for those reasons, not binding or subject to vacatur. The decision in *Anthem Blue Cross & Heath Ins. Co. v. HaloMD LLC*, 2026 WL 982629 (C.D. Cal. Apr. 9, 2026), focused almost entirely on whether the court could review determinations made by IDREs on whether a dispute was eligible for inclusion in the IDR process, which is not the issue here. (*Id.* at *8.) In *Aetna Health, Inc. v. Radiology Partners, Inc.*, 2026 WL 155164, at *3 (M.D. Fla. Apr. 15, 2026),"[w]hile a close call," the court found that Aetna failed to allege a sufficient basis to challenge IDR awards that "were wrongfully submitted by in-network providers" because Aetna admittedly knew the defendants were engaged in those very actions long before the IDR proceedings were filed but failed to raise it in the IDR proceedings.

D. <u>The Complaint Is Not Procedurally Defective</u>

Relying solely on *GPS of New Jersey MD P.C. v. Aetna, Inc.*, 2024 WL 414042 (D.N.J. Feb. 5, 2024), Rowe argues vacatur cannot be sought by filing a Complaint. The court in *GPS* stated "that in seeking to vacate the arbitration award entered by MCM, 'Plaintiff should have proceeded by filing *either* (i) a petition to vacate the arbitration award in lieu of a complaint, or (ii) a complaint followed by a motion to vacate the arbitration award.'" *Id.* at *2. Regardless, the *GPS* court further held that

"the Third Circuit has indicated that a district court has the discretion to construe a plaintiff's complaint as a motion to vacate the arbitration award. *Id.* (citing *Oberwager v. McKechie, Ltd.*, 351 F. App'x 708, 709 n.2 (3d Cir. 2009). If necessary, the court can do so here.

Rowe conveniently ignores that the NSA incorporates only Section 10 of the FAA, but not the procedural requirements in Sections 6 and 9, including that vacatur must be sought by motion. *See Med-Trans Corp.*, 700 F. Supp. 3d at 1084 (holding that the FAA's procedural requirements do not apply to challenging an IDR award under the NSA; (*see* Compl. ¶ 390). Notably, in the two decisions discussed above, the courts did not hold the actions were procedurally defective because plaintiffs had filed complaints seeking to vacate NSA awards in each action. Here, Emblem properly filed a Complaint and fully intends to make a motion to vacate the awards after it has obtained discovery, including Rowe's submissions to the IDRE.

E. <u>The Noerr-Pennington Doctrine Does Not Apply</u>

Rowe cites no decision applying the doctrine to the NSA and we are aware of none. Given that the NSA explicitly provides that IDR awards may be vacated on various grounds, Congress quite obviously did not intend to immunize IDR awards under the Noerr-Pennington doctrine.

Even if the *Noerr-Pennington* doctrine had any applicability, it would not immunize Rowe against fraud. *See Amphastar Pharms. Inc. v. Momenta Pharms.*,

Inc., 850 F.3d 52, 56 (1st Cir. 2017) (internal quotation marks, citation, and alteration omitted.)) The Third Circuit has noted that "a *material* misrepresentation that affects the very core of a litigant's . . . case will preclude *Noerr–Pennington* immunity." *Cheminor Drugs, Ltd. v. Ethyl Corp.*, 168 F.3d 119, 123-24 (3d Cir. 1999) (emphasis in original). *See also U.S. Futures Exch., L.L.C. v. Bd. of Trade of the City of Chi., Inc.*, 953 F.3d 955, 960 (7th Cir. 2020). At the very least, "[D]istrict courts within this Circuit have routinely prohibited parties from invoking the protections of *Noerr-Pennington* at the dismissal stage of a case . . . at which time the factual record remains undeveloped and insufficient . . . ." *Takeda Pharm. Co. Ltd. v. Zydus Pharm. (USA) Inc.*, 358 F. Supp. 3d 389, 394-95 (D.N.J. 2018) (emphasis in original). *See Am.. Specialty Health Grp., Inc. v. Ass'n of N.J. Chiropractors, Inc.*, 2021 WL 12101070, at *3 (D.N.J. Jan. 22, 2021).

F. <u>The Complaint Is Not Subject To Dismissal As A Group Pleading</u>

Where, as here, "'entities are intertwined through a complex corporate structure[,] [p]laintiffs cannot be expected to know the exact corporate structure and degree of each [d]efendant's involvement at th[e motion to dismiss stage] and prior to discovery." *McMahon v. Volkswagen Aktiengesellchaft*, 2023 WL 4045156, at *10 (D.N.J. Jun. 16, 2023) (quoting *In re Volkswagen Timing Chain Prod. Liab. Litig.*, 2017 WL 1902160, at *9 (D.N.J. May 8, 2017)). "This exception relaxes the level of specificity required in a complaint under Rule 8 and Rule 9(b)." *Id.*; *see Yu-*

Chin Chang v. Upright Fin. Corp., 2020 WL 473649, at *3 (D.N.J. Jan. 28, 2020). Dr. Rowe knows exactly what role he and the other Defendants played in the wrongdoing alleged in the Complaint. None of them has any basis on which they could "claim[] to be in the dark about the actions of the other Defendants." *McMahon*, 2023 WL. 4045156, at *10.

The cases Rowe relies upon do not support dismissal. In *JD Glob. Sales, Inc. v. Jem D Int'l Partners, LP*, 2023 WL 4558885 (D.N.J. July 17, 2023), the court found the complaint was an impermissible group pleading because "the lack of well-pleaded facts does not allow the Court to 'draw the reasonable inference that [each] defendant is liable for the misconduct alleged' and because the complaint "forc[ed] both the [d]efendants and the court to guess who did what to whom and when." *Id.* at *7. The same cannot be said of the Complaint here, which is more than "sufficient to put Defendants on notice as to the claims against them." *Id*. *Bussinelli v. Twp. Of Mahwah*, 2024 WL 3755914 (D.N.J. Aug. 12, 2024), and *Galicki v. New Jersey*, 2015 WL 3970297 (D.N.J. June 29, 2015), are equally inapposite. In both cases, unlike here, an entity defendant was lumped together with a group of *individual defendants*. In *Bussinelli*, "[t]he [c]omplaint repeatedly ma[de] legal conclusions regarding the involvement of these [individual d]efendants without specifying facts as to the particular misconduct alleged or their specific role in the alleged misconduct." 2024 WL 3755914, at *4. Such a pleading "fail[ed] to place individual

defendants on notice of the particular claims against them." *Id*. Likewise, in *Galicki*, the complaint "fail[ed] to allege the personal involvement of any [individual d]efendant as is required." 2015 WL 3970297, at *2. Here, by contrast, the Defendants are all entities under the common ownership, control and direction of the sole individual defendant, Dr. Rowe.[4]

IV. THE MOTION TO DISMISS COUNTS III–VI SHOULD BE DENIED

A. Plaintiff's State Law Claims Are Not Preempted By The NSA

Rowe does not cite any decision from this Circuit in which a court has held that the NSA's statutory grounds to vacate an IDR award preempt state law causes of action seeking relief other than vacatur. Although the Third Circuit has not yet spoken on the preemption issue, Judge Martinotti has opined that:

> For federal law to preempt state law, there must be a specific "[c]onflict ... where compliance with both [federal and state law] ... is a physical impossibility," or Congress must have "intended federal law to occupy the field ... [with t]he intent to displace state law altogether." Far from expressing preclusive intent, the NSA's preemption clause is clear: "[The NSA] shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any standard or requirement solely relating to health insurance issuers in

[4] Rowe half-heartedly argues Emblem lacks standing. While conceding the Complaint satisfies two of the three requirements to plead standing (*i.e.*, Emblem suffered an injury-in-fact and the relief sought will redress that harm), Rowe argues the Complaint fails to plead a "connection between the asserted injury-in-fact and the alleged actions of the defendant " (Moving Memo at 24.) This argument has no merit. The Complaint pleads a direct and logical causal connection between Rowe's fraudulent scheme and irrational IDR awards that the fraud was intended to and, in fact did, produce. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992).

> connection with individual or group health insurance coverage except to the extent that such standard or requirement prevents the application of a requirement of [the NSA.]"

Modern Orthopaedics of NJ v. Premera Blue Cross, 2025 WL 3063648, at *11-12 (D.N.J. Nov. 3, 2025) (quoting *Lozano v. City of Hazleton*, 724 F.3d 297, 303 (3d Cir. 2013)). Similarly, in *SpecialtyCare Inc. v. Aetna, Inc.*, 2025 WL 3719227, at *3 (M.D. Pa. Dec. 23, 2025), while declining to "reach the question as to whether Plaintiffs' state law claims are preempted," the Court expressed skepticism: "With respect to the NSA, rather than preempt state action, *Congress explicitly included states as part of the statutory design*. . . . [and] *wanted states to continue to play a role in regulating the health insurance marketplace*." 2025 WL 3719227, at *3 (emphasis added).

Rowe cites nothing in the NSA suggesting that Congress intended to preempt a New Jersey statute, like the Insurance Fraud Prevention Act ("NJIFPA"), that is designed to curb fraud in the insurance marketplace, or common law remedies against providers who engage in wrongdoing, especially outside the IDR process. There is a presumption that Congress does not generally intend to displace state law unless it expressly makes clear its intention to do so in the federal statute at issue. *See Maryland v. Louisiana*, 451 U.S. 725, 746 (1981).

The relief that Emblem seeks in connection with the NJIFPA, fraud, negligent misrepresentation and unjust enrichment claims is not to challenge the awards at

issue; that relief is sought only in connection with the First and Second Causes of Action. These state law claims are not "competing" with the NSA, they seek different relief altogether (*i.e.,* compensatory and punitive damages) based, in part, on Rowe's submission of claims to Emblem outside the NSA process.

Defendants rely on a *single* unpublished decision from the Middle District of Florida. *See Aetna Health Inc. v. Radiology Partners, Inc.*, 24-cv-1343-BJD-LLL, Order dated April 16, 2026 (Docket No. 105). Notably, neither of the decisions cited in *Aetna Health* holds the NSA preempts state law claims. The court's conclusion in *Reach Air Med. Servs.*, 160 F.4th at 1115, that "[n]othing in the [NSA] . . . has altered [the] limited scope of judicial review" under the FAA says nothing about the NSA preempting a state law claim that does not seek to vacate an IDR award. And, *Marmet Health Care Ctr., Inc. v. Brown*, 565 U.S. 530, 533 (2012), merely says the *FAA* preempts state statutes that "frustrate its purpose."

B. The Complaint Adequately Alleges A Cause Of Action For Violation Of The New Jersey Insurance Fraud Prevention Act

A violation of the NJIFPA occurs when a person or entity "[p]resents or causes to be presented any written or oral statement as part of, or in support of . . ., a claim for payment or other benefit pursuant to an insurance policy . . . knowing that the statement contains any false or misleading information concerning any fact or thing material to the claim." N.J.S.A. 17:33A-4(a)(1). "Unlike common law fraud, proof of fraud under the [NJIFPA] does not require proof of reliance on the false statement or resultant

damages ... nor proof of intent to deceive." *Horizon Blue Cross Blue Shield of N.J. v Transitions Recovery Program,,* 2015 WL 8345537 at *4 (D.N.J. Dec. 8. 2015). "Thus a claim under the NJIFPA requires much less thorough pleading than a claim for common law fraud." *Gov't Emps. Ins. Co. v. Zuberi,* 2017 WL 4790383, at *4 (D.N.J. Oct. 23, 2017). Moreover, "[courts] must construe the [NJIFPA's] provisions liberally to accomplish the Legislature's broad remedial goals." *Lincoln Na'l. Life Ins. Co. v. Schwarz,* 2010 WL 3283550, at *16 (D.N.J. Aug. 18, 2010) *(*quoting *Liberty Mut. Ins. Co. v. Land,* 186 N.J. 163, 892 A.2d 1240 (N.J. Sup. Ct. 2006)). Where, as here, the Complaint alleges that the Defendant "prepare[d] a writing containing materially false statements . . . in order to support [its] insurance claims," it "sufficient[ly] . . . assert[s] a claim pursuant to the NJIFPA." *Virginia Sur. Co. v. Macedo,* 2011 WL 1769858, at *16 (D.N.J. May 6, 2011).

Rowe argues the Third Cause of Action for violation of the NJIFPA fails because the amounts they billed Emblem in the claim forms they submitted were "merely the amount the provider elect[ed] to bill" and what they were paid were "the out-of-network benefit dictated by the NYC PPO Plan, not Defendants' billed charges." (Moving Memo at 25.) Rowe attempts to rewrite the Complaint to fit their Motion. The Complaint alleges that Rowe knowingly submitted fraudulent claims/claim forms to Emblem outside the IDR process. Thus, while Rowe was submitting claims representing that his billable charge "was first $150,000 and later

$300,000 for the primary surgeon, and approximately $45,000 to $300,000 for the assistant surgeon" (Compl. ¶ 409), they knew these amounts were fictitious because "[a]s a result of their practice of fee forgiving, the amount Rowe was charging their patients were significantly less than the amount Rowe was misrepresenting to Emblem was their billable charge." (*Id.* ¶ 410.) Rowe argues this is insufficient because the Complaint fails to allege "that Emblem paid any amount in reliance on them." (Moving Memo at 25.) Rowe ignores, however, that the NJIFPA does not require proof of reliance on the false statement or resultant damages.

Relying on *Frederico v. Home Depot*, 507 F.3d 188 (3d Cir. 2007), Rowe argues the NJIFPA claim fails to provide the particularity required under Rule 9(b). *Frederico* involved a claim for common law fraud. In any event, as the court explained in *Frederico*, Rule 9(b) merely requires a plaintiff to "plead or allege the date, time and place of the alleged fraud or otherwise inject precision or some measure of substantiation into a fraud allegation." 507 F.3d at 200. The Complaint here alleges the dates Rowe electronically filed each claim, along with the amounts claimed. The Complaint pleads facts that are more than sufficient to provide the "who, what, when, where, and how" that Rule 9(b) requires. *In re Burlington Coat Factory Secs. Litig.*, 114 F.3d 1410, 1422 (3d Cir. 1997); *see also U.S. ex. rel. Moore & Co., P.A. v. Majestic Blue Fisheries, LLC*, 812 F.3d 294, 307 (3d Cir. 2016). The Complaint provides Rowe with the required notice and more.

C. The Cause Of Action For Unjust Enrichment Should Not Be Dismissed

The Complaint plausibly alleges that, through deceptive and improper means, Rowe unjustly obtained a massive benefit at the expense of Emblem and its insureds. This is sufficient to plead a claim for unjust enrichment. *See, e.g., Gurjal v. BMW of N. Am., LLC*, 2022 WL 3646627, at *6 (D.N.J. Aug. 23, 2022); *VRG Corp. v. GKN Realty Corp.*, 135 N.J. 539, 554 (N.J. 1994); *Prima v. Darden Rests., Inc.*, 78 F. Supp. 2d 337, 355 (D.N.J. 2000); Pontrelli *v. MonaVie, Inc.*, 2014 WL 4105417, at *7 (D.N.J. Aug. 19, 2014).

Rowe's sole argument is that an unjust enrichment claim is "unavailable where the conduct at issue is governed by a comprehensive statutory scheme providing an adequate legal remedy." (Moving Memo at 26.) This argument ignores that Rowe has moved to dismiss the statutory claims it argues provide an adequate legal remedy. If this Court (contrary to the arguments set forth above) were to find that the IDR awards are binding and *not* subject to vacatur, this alternative cause of action for unjust enrichment should not be dismissed because the NSA obviously does *not* provide an adequate legal remedy.

Rowe argues that *Est. of Gleiberman v. Hartford Life Ins. Co.*, 94 F. App'x 944, 947 (3d Cir. 2004), supports dismissal because the unjust enrichment claim is "impermissibly duplicative" of Emblem's statutory and declaratory claims under the NSA and for common law fraud. In *Estate of Gleiberman*, because "the contract

[wa]s valid and enforceable, the District Court correctly dismissed the claims for unjust enrichment . . . .” noting that such a claim is “only supportable when the parties’ rights are not governed by a valid, enforceable contract.” 94 F. App’x at 947. There is no contract between Emblem and Rowe.

D. The Fifth And Sixth Causes Of Action For Fraud And Negligent Misrepresentation Should Not Be Dismissed

The only arguments advanced by Rowe in support of dismissal of the fraud and negligent misrepresentation claims are that: (a) the claims are supposedly not pled with sufficient particularity; and (b) the Complaint allegedly fails to allege Emblem’s reliance. Neither argument has any merit.

For the same reasons discussed above, the Complaint satisfies Rule 9(b).[5] Although Rowe argues “the alleged misrepresentations were directed to the IDREs, not to Emblem,” each IDRE was an instrumentality through which Rowe’s fraudulent scheme was perpetrated on Emblem, the target and victim. “New Jersey does not require that a misrepresentation be made *to* plaintiff himself in order to be actionable.” *Union Trust Co. v. Md. v. Wakefern Food Corp.*, 1989 WL 120756, at *24 (D.N.J. Sept. 8, 1989) (emphasis added) (*citing Judson v. Peoples Bank & Trust*

[5] The Complaint pleads that Defendants engaged in the same fraud with respect to each of the IDR Proceedings listed in Exhibit A to the Complaint and uses five IDR Proceedings as exemplars. (Complaint ¶¶ 120, 377 – 384, 409 - 420.) Although Emblem submits there is no pleading defect, to the extent the Court determines that such details must be plead with respect to each of the IDRs in Exhibit A, Emblem should be permitted to amend and requests leave to do so.

Co., 25 N.J. 17, 24–27 (1957). It suffices "that the defendant intend it to be communicated to and relied upon by plaintiff." *Parker Precision Prods. Co. v. Metro. Life Ins. Co.*, 407 F.2d 1070, 1076 (3d Cir.1969). *See also Metric Inv., Inc. v. Patterson*, 101 N.J. Super. 301, 309 (App. Div.1968) (emphasis added). That is precisely what the Complaint alleges here. As the Supreme Court noted, "under the common law[,] a fraud may be established when the defendant has made use of a third party to reach the target of the fraud." *Tanner v. U.S.*, 483 U.S. 107, 129 (1987).

Finally, whether Emblem reasonably relied is a question of fact that is unsuited for resolution on a motion to dismiss. *See Thomas v. Williams*, 2024 WL 2795895, at *2 (D.N.J. May 31, 2024); *Yanes v. Minute Maid Co.*, 2006 WL 1207992, at *5 (D.N.J. May 3, 2006); *Union Trust*, 1989 WL 120756, at * 25.

E. Dr. Rowe Is Properly Named As A Defendant

As "the New Jersey Supreme Court held: . . . 'a corporate officer can be held personally liable for a tort committed by the corporation when he or she is sufficiently involved in the commission of the tort.'" *Kenney v. M2 Worldwide, LLC*, 2013 WL 3508564, at *1 (D.N.J. Jul. 11. 2013) (quoting *Saltiel v. GSI Consultants, Inc.*, 170 N.J. 297, 303 (2002)). *See also Adam v. Barone*, 2023 WL 3058724, at *3 (D.N.J. Apr. 24, 2023). Dr. Rowe owns, controls and directs the actions of the Defendants. It was Dr. Rowe who orchestrated and directed the fraud; it was Dr. Rowe who decided to have the surgeries performed at an in-network hospital instead

of an ASC; it was Dr. Rowe who decided which practice entity would submit claims and initiate IDRs; it was Dr. Rowe who decided what Rowe's billable charge should be for each of the fraudulent claims he caused Rowe to submit to Emblem. Likewise, it was Dr. Rowe who decided what amounts to propose in Rowe's Open Negotiation Offers to Emblem, what offers to submit to the IDREs, and what information to include and misrepresent in the IDR submissions. This is more than a sufficient basis for Dr Rowe to be a party.

V. THE REQUEST TO STAY SHOULD BE DENIED

The mere filing of a motion to dismiss does not constitute good cause to stay discovery. *Udeen v. Subaru of Am., Inc.*, 378 F. Supp. 3d 330, 332 (D.N.J. 2019) (applying four factor test); *see also Gerald Chamales Corp. v. Oki Data Ams., Inc.*, 247 F.R.D. 453, 454 (D.N.J. 2007); *United Healthcare Servs., Inc. v. Teva Pharm. USA, Inc.*, 2023 WL 6558058 (D.N.J. May 11, 2023). Because "the stay of a civil proceeding constitutes 'an extraordinary remedy'", such motions are disfavored and the moving party bears the heavy burden of showing good cause for a stay. *Akishev v. Kapustin*, 23 F. Supp. 3d 440, 445 (D.N.J. 2014) (quoting *Walsh Sec. Inc. v. Cristo Prop. Mgmt, Ltd.*, F. Supp. 2d 523, 526 (D.N.J. 1998).

Rowe has not come close to meeting their burden. To the contrary, a stay would prejudice Emblem and create a tactical advantage for Rowe, who is desperate to avoid disclosure of the documents they submitted to the IDREs. Rowe has neither

argued nor established that they will be prejudiced if discovery goes forward. *Udeen*, 378 F. Supp. 3d at 333.; *see Coyle v. Hornell Brewing Co.*, 2009 WL 1652399 (D.N.J. June 9, 2009), *Landis v. N. Am. Co.*, 299 U.S. 248, (1936) *See also United Healthcare Servs., Inc.*, 2023 WL 6558058. Rowe's reliance on *Mann v. Brenner*, 375 F. App'x. 232 (3d Cir. 2010) is misplaced. In *Mann*, the Third Circuit affirmed a stay because the plaintiff's complaint was legally insufficient across all claims. That is not the case here.

CONCLUSION

For the foregoing reasons, Rowe's Motion should in all respects be denied.

Dated: New York, New York
June 22, 2026

Respectfully submitted,

TARTER KRINSKY DROGIN LLP

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UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

EMBLEMHEALTH, INC., Plaintiff, -against- NORMAN M. ROWE, M.D., NORMAN M. ROWE, M.D. PLLC, NORMAN M. ROWE MD OF NEW JERSEY LLC, ROWE PLASTIC SURGERY OF NEW JERSEY LLC, and EAST COAST PLASTIC SURGERY PLLC PA, Defendant(s).	Case No. 26-cv-3311 (SDW) (MAH)

DECLARATION OF ARTHUR PERRY, M.D.

I, Dr. ARTHUR PERRY, of full age, hereby state as follows:

A. Background/Qualifications

1. I am a plastic surgeon, certified by the American Board of Plastic Surgery, Inc. and licensed currently in New Jersey, New York and California. I have been practicing plastic surgery since 1987.

2. I graduated from the Albany Medical College of Union University, New York, in 1981 with a Doctor of Medicine with Distinction in Research.

3. After graduation, I interned in Surgery at Beth Israel Hospital/Harvard Medical School in Boston, Massachusetts, from 1981-1982. I then was a general surgical resident at Beth Israel Hospital/Harvard from 1982-1984. During this period of 1981-1984, I held the faculty rank of Clinical Fellow in Surgery at Harvard University. From 1984-1985, I was a Clinical Fellow in Burn Surgery at the New York Hospital, holding the faculty rank of Fellow at Cornell University Medical College in New York. From 1985-1987, I was a resident in plastic and reconstructive surgery at the University of Chicago and was the Chief Resident there from 1986-1987. In 1987, I was a Fellow in Aesthetic Surgery at Baker-Gordon Associates in Miami, Florida.

4. I was a full time Assistant Professor of Plastic Surgery at Rutgers – Robert Wood Johnson Medical School from 1987-1988 and a Clinical Associate Professor there from 1988 until I was promoted to Clinical Associate Professor in 1997, a position that I currently hold. I was a Clinical Associate in Surgery at the University of Pennsylvania School of Medicine from 1993-2007, where I supervised the resident cosmetic surgery clinic. I have been an Adjunct Associate Professor of Plastic Surgery at Columbia University in New York from May 2012 thru the present. I have an active role in the Cornell/Columbia plastic surgery residency program, serving as a team leader for the Transition to Practice Rotation, teaching residents on-site in my New York office.

5. I have hospital privileges at Robert Wood Johnson University Hospital in New Brunswick, New Jersey, at the Lenox Hill Hospital/Manhattan Eye, Ear & Throat Hospital in New York City and at the St. Peter's Hospital CARES surgicenter in New Brunswick, New Jersey. I had privileges at Robert Wood Johnson University Hospital in Somerville, New Jersey, from 1990 to 2021 where I was the Chief of Plastic Surgery from 2003 through 2005.

6. I was a Member of the New Jersey State Board of Medical Examiners ("State Board") from 1995 through 2005. While on the State Board, I was Chairman of the Board's Advertising Committee from 1997 thru 2005, and also was Chairman of the South Jersey Preliminary Evaluation Committee, where I personally evaluated several thousand complaints against physicians and made recommendations whether action should be taken against their licenses. I was appointed to the State Board by Governor Whitman in large part because of my personal disdain for insurance fraud by plastic surgeons. I have continuously consulted with the State Board from 1990 thru the present.

7. As an active plastic surgeon, I have performed thousands of breast reduction procedures. Breast reductions are a basic part of the training of a plastic surgeon and are one of the most technically simpler and common procedures performed. A breast reduction can typically be performed in 2 to 5 hours as an outpatient procedure. It need not be performed in a hospital.

8. In my entire career as a physician, from graduation in 1981 to the present, I have never been sued for malpractice and have never had a complaint waged against me.

B. The Cost Of A Breast Reduction

9. My billable charge is currently approximately $25,000 for a bilateral breast reduction, which is the amount I expect my patients to pay. Although there is some variability in plastic surgeon's fees, my billable charge is consistent with what I understand to be the generally prevailing billable charge for a breast reduction in New Jersey and New York and is based on my training, extensive experience, and surgical competence. My fee of $25,000 is typical of my colleagues that I work with at the Cornell and Columbia teaching program, and Manhattan Eye, Ear, and Throat Hospitals. It is slightly higher than the typical fees of my colleagues at Robert Wood Johnson and the St. Peters CARES Surgicenter in New Jersey.

10. The American Society of Plastic Surgeons ("ASPS"), the largest plastic surgery society in the United States, releases annual data documenting physician fees for surgical and nonsurgical procedures. For 2024, the average cost of a breast reduction according to ASPS was $7,000 to $12,500. This is for the surgeon's fee only and excludes the costs of the anesthesiologist, supplies and operating room charges. This fee typically includes preoperative visits, excluding the initial consultation, and all postoperative visits for a minimum of 3 months. (A copy of the 2024 Average Surgeon/Physician Fees from the ASPS's website is annexed hereto as Exhibit "A".)

11. I understand that Dr. Rowe's billable charge for a breast reduction is $300,000 for the primary surgeon and $300,000 for the assistant surgeon. The combined billable charge of $600,000 for a breast reduction is completely irrational. I am not aware of any support for such a wildly exorbitant fee.

12. I understand that Dr. Rowe was awarded fees by Independent Dispute Resolution Entities for breast reductions all the way up to $440,000, including $220,000 for each of the primary and assistant surgeons in a single surgery. These awards bear absolutely no relation to the prevailing cost of a breast reduction in New Jersey and New York, which is a fraction of these completely irrational amounts.

13. Routine breast reduction surgery does not require an assistant surgeon. I typically perform breast reductions only with the assistance of a nurse or surgical technician. From a medical standpoint, a second surgeon is not necessary, although the presence of a second surgeon will shorten the procedure by approximately one-third of the surgical time. The typical surgical fee awarded to an assistant is generally 16% to 20% of the primary surgeon's fee.

14. I am aware of no support or justification for a plastic surgeon billing $600,000 or being paid $440,000 or any amount remotely close to this for a routine breast reduction. In my

professional opinion, and based upon my lengthy experience, these amounts are completely irrational, especially in view of the generally prevailing rate which is a small fraction of these amounts.

I declare under the laws of the United States of America that the foregoing is true and correct.

Dated: June 18, 2026

ARTHUR PERRY, M.D.

Exhibit A

2024 ASPS Procedural Statistics Release

AMERICAN SOCIETY OF PLASTIC SURGEONS®

Table of Contents:

Introduction

The American Society of Plastic Surgeons (ASPS), a nonprofit organization, supports its members in their efforts to provide the highest quality patient care through education, research and advocacy.

It is the largest organization of board-certified plastic surgeons in the world. With more than 9,000 members across the globe, the Society is recognized as a leading authority and information source on cosmetic and reconstructive plastic surgery.

Founded in 1931, the Society represents physicians certified by the American Board of Plastic Surgery (ABPS) or the Royal College of Physicians and Surgeons of Canada.

The ASPS mission is to provide high-quality care to plastic surgery patients by encouraging high standards of training, ethics, physician practice and research in plastic surgery. ASPS Member Surgeons are uniquely qualified to perform cosmetic and reconstructive plastic surgery on the face and all areas of the body.

A Message from ASPS President Scott Hollenbeck, MD

These ambiguous economic times defined one clear trend: Patients continue to value and invest in plastic surgery procedures and treatments. Despite economic uncertainty, demand remained steady in 2024, showing us more and more patients are prioritizing their aesthetic health because it contributes to an overall better mental mindset and physical health. No matter the economy, people want to look and feel their best, so they feel prepared to face the challenges of everyday life.

Plastic surgery goes far beyond aesthetics. It also includes reconstructive surgeries that span every age group, from infants to seniors. In 2024, this category saw the largest growth, with a 2% increase. Trauma, illness and birth defects often leave behind visible and invisible scars that can impact patients' long-term quality of life and mental well-being. Plastic surgeons are key members of care teams who guide the healing process since they specialize in repairing complex structures, helping patients heal physically and emotionally. The data suggests reconstructive work remains in high demand.

Minimally invasive treatments remain popular, both as part of self-care regimens and as an affordable luxury. Injectables, including neuromodulators such as Botulinum toxin injections, commonly known as Botox®, fillers and lip augmentation, reign as favorites because they offer little downtime, few side effects and almost immediate results at an affordable price point.

For the first time, we measured prescription weight loss medications. These drugs help people live healthier lives, but also are reshaping their bodies and features. Plastic surgeons are a critical component in many people's weight loss journey because they rejuvenate and contour faces and bodies. This allows people to feel at ease and confident in their new bodies.

Plastic surgeons have always led the medical field in cutting-edge advancements, yet patient safety and education remain our top priorities. Board-certified plastic surgeons remain the gold standard in care by providing safe, effective treatment, both reconstructive and aesthetic. ASPS Member Surgeons are worth the investment because we empower patients by supporting their whole health and informed decision-making.

This report shows us where plastic surgery was in 2024 and provides glimpses into its future. Each number represents a real person who was transformed on the outside, and most likely the inside as well, by the skilled hands of a plastic surgeon who helps restore confidence, function or well-being. This data not only helps to create informed conversations around the intricacies of our profession but also highlights the commitment of ASPS Member Surgeons to excellence, innovation and, above all, patient safety.

I sincerely thank all ASPS Member Surgeons who contributed to this report with both data and expert insights. I am also grateful to everyone who designed and published this report to make it accessible to both plastic surgeons and the wide range of people who will use it for a variety of purposes.

This report does not close the book on plastic surgery. Instead, the data opens the dialogue for us to start writing the next chapter to shape the future of the specialty, ensuring that we always prioritize the people behind the numbers.

Sincerely,

Scott Hollenbeck, MD
President, American Society of Plastic Surgeons

Overall Trends

Looking back at 2024, it can feel like a lot has changed in just a few short months. We're now several years outside of a global pandemic and have had time to recover, only to see new economic uncertainty with indications of patients holding off on spending and considering a more conservative approach to their aesthetic health. Despite economic ups and downs impacting patients' wallets, healthcare and aesthetic goals, the demand for surgical and minimally invasive plastic surgery procedures remained steady in 2024, showing that Americans are still prioritizing their aesthetic health, even in times of uncertainty or little economic growth.

Overall Growth Trends for 2024

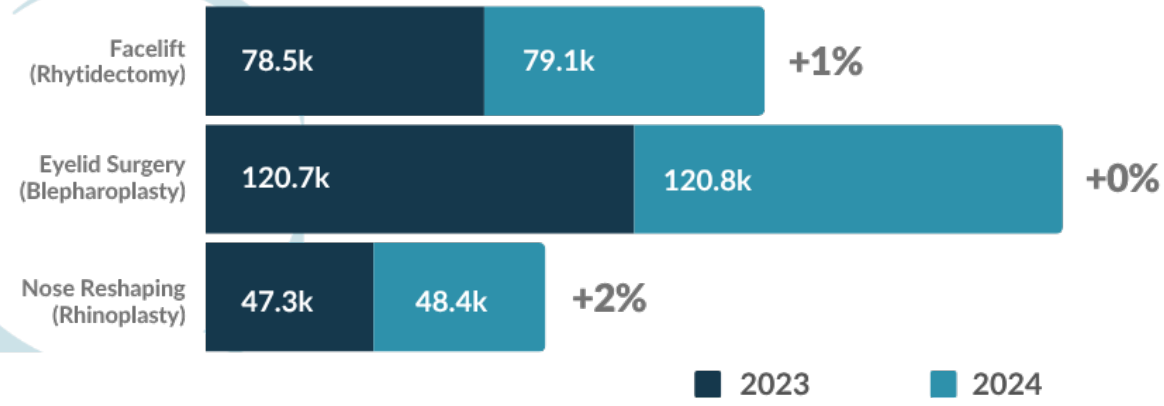
At first glance, the numbers for 2024 seem consistent. However, the story they tell suggests that the demand for surgical and minimally invasive procedures isn't going anywhere. There is no significant increase, but the most interesting aspect of these new numbers is that there was no major decrease in plastic surgery procedures among ASPS Member Surgeon practices, despite perceptions in the greater market of economic uncertainty.

Liposuction Tops the Charts Again

Liposuction tops the 2024 statistics report as the most popular surgical plastic surgery procedure, with a 1% increase in individuals opting for the procedure in 2024 vs 2023. It may be a modest increase from the previous year's numbers, but any increase is statistically interesting due to the rise in popularity of GLP-1 medications for weight loss. With more patients turning to weight loss medications, there may be an assumption that the demand for liposuction would decrease. So far, the 2024 numbers show a steady demand for the procedure.

Liposuction continues to be one of the most commonly performed procedures, valued for its versatility and ability to target specific areas of the body. Often used in combination with other surgeries or as a standalone treatment, liposuction helps contour and refine areas like the abdomen, thighs, arms, and neck, enhancing overall shape and achieving a more balanced aesthetic.

Increases in Key Face and Neck Cosmetic Surgical Procedures Since 2023



Credit: The American Society of Plastic Surgeons - Procedural Statistics Release (2024)

Overall Trends *(Continued)*

Breast Is Best

In terms of surgical procedures, breast augmentation remains one of the most popular procedures. The 2024 data shows that breast augmentation involving implant placement for both primary and revision implant surgeries, increased slightly over 2023 statistics.

Breast augmentation procedures rose 1% in 2024; it's not a huge jump, but it indicates that a procedure such as breast augmentation is still in demand despite economic uncertainty. That is an interesting outcome considering many patients are winding down their spending on "big ticket" expenditures as economic headwinds shift.

Lower Body Sculpting

One of the more notable trends in body procedures this year is the increase in lower body sculpting procedures. Thigh lifts saw a significant increase in patients during 2024, with a 3% increase in patients getting the procedure from 2023. Last year, 9,914 individuals opted for a thigh lift. The only other surgical procedure to see a 3% increase over the previous year was also a lower body sculpting procedure – the buttock lift.

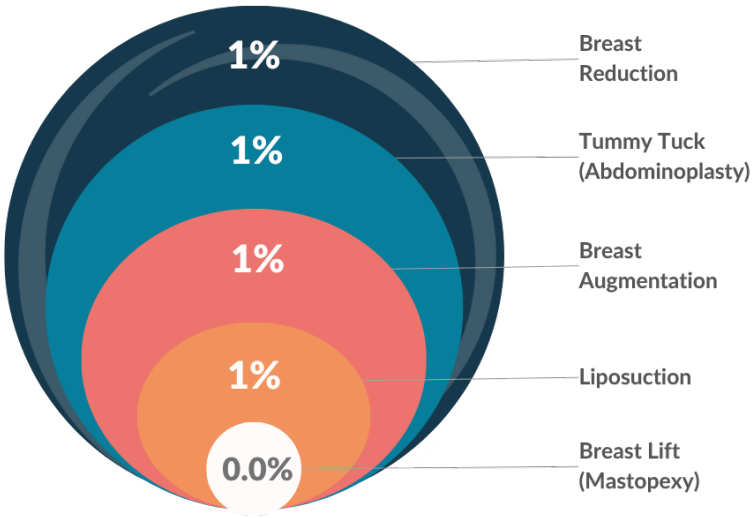
Minimally Invasive Trends

Injectables continue to be a popular option for many patients as neuromodulator injections like Botox® represent a 4% jump year over year. These injections maintain their number one spot in the minimally invasive category, possibly due to the aforementioned Botox®, but also Dysport®, Xeomin® and Jeuveau® – helping almost 10 million patients smooth fine lines in 2024.

Hyaluronic acid (HA) fillers are still among the most popular minimally invasive offerings, with 5,331,426 patients opting to enhance their features with fillers, and 1,589,502 patients choosing HA fillers to perfect their pout. Non-hyaluronic acid fillers, such as Radiesse, Sculptra, Bellafill and Renuva, also held steady in 2024 with 932,861 procedures performed.

Botox® and HA fillers tend to garner most of the spotlight as they are continually the most popular minimally invasive procedures, but non-HA fillers are also having a moment. Patients are increasingly choosing these fillers for longer-lasting results. Last year the number of patients opting for non-HA fillers rose 1% over the prior year.

Increases in Chest and Core Cosmetic Procedures Reported Since 2023



Credit: The American Society of Plastic Surgeons - Procedural Statistics Release (2024)

2024 Cosmetic Surgery Procedures

COSMETIC SURGERY PROCEDURES	2024	2023	% CHANGE 2024 vs 2023
COSMETIC SURGERY PROCEDURES - BREAST			
Breast augmentation (implant placement for both primary and/or revisions)**	**306,196**	304,181	1%
Breast implant removals (augmentation patients only)**	**41,271**	41,115	0%
Breast lift (mastopexy)**	**153,616**	153,600	0%
Breast reduction**	**76,734**	76,031	1%
Breast reduction in males (gynecomastia surgery)**	**26,430**	25,888	2%
COSMETIC SURGERY PROCEDURES - BODY			
Abdominoplasty (tummy tuck)**	**171,064**	170,110	1%
Buttock augmentation with fat grafting**	**29,466**	29,383	0%
Buttock implants**	**1,245**	1,234	1%
Buttock lift**	**7,954**	7,748	3%
Labiaplasty**	**10,827**	10,631	2%
Liposuction	**349,728**	347,782	1%
Lower body lift**	**10,957**	10,947	0%
Thigh Lift**	**9,914**	9,600	3%
Upper arm lift (brachioplasty)**	**23,527**	23,058	2%
COSMETIC SURGERY PROCEDURES - FACE			
Buccal fat pad removal**	**4,903**	4,866	1%
Cheek implant (malar augmentation)**	**9,130**	8,825	3%
Chin augmentation (mentoplasty)**	**5,529**	5,484	1%
Ear surgery (otoplasty)**	**4,825**	4,817	0%
Eyelid surgery (blepharoplasty)**	**120,755**	120,747	0%
Facelift (rhytidectomy)**	**79,058**	78,482	1%
Facial fat grafting**	**34,260**	34,216	0%
Forehead lift**	**13,621**	13,518	1%
Liposuction (submental/chin)**	**24,000**	23,667	1%
Neck lift**	**22,445**	22,007	2%
Nose reshaping (rhinoplasty)**	**48,423**	47,307	2%
TOTAL	**1,585,878**	**1,575,244**	**1%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

Top 5
Cosmetic Surgical Procedures for 2024

1 Liposuction

It's no surprise that liposuction still remains the number one cosmetic surgery procedure. ASPS Member Surgeons often provide liposuction as an additional option with procedures such as abdominoplasty (tummy tuck), breast augmentation and others.

2 Breast Augmentation

Breast augmentation has long been one of the most popular surgical procedures. Innovations in breast implant design and technology can offer a more natural look and feel, and may be helping to accelerate the trend of patients looking for lower-volume implants to give them a proportional look.

3 Abdominoplasty

Making an appearance in the top five for four consecutive years is the tummy tuck. Popular as part of a "mommy makeover" for postpartum mothers, the tummy tuck may continue to remain in a top spot because of increased interest in GLP-1 weight loss medications, such as Ozempic®.

4 Breast Lift

Elevating and reshaping the breasts while leaving the size unchanged, women often seek this procedure to restore the contour of their bust after pregnancy, breastfeeding, weight fluctuation or aging. It further focuses on improved symmetry and silhouette with minimal downtime and long-lasting results without implants.

5 Blepharoplasty

Making an appearance in the top five for a third year in a row, blepharoplasty (eyelid surgery) remains a popular way to refresh the face. It removes excess skin, fat and tissue that can weigh down the eyes, giving patients a rested and refreshed aesthetic. Depending on their goals, patients can focus on the upper or lower eyelids – or both.

Trend to Watch: Facelift

A facelift can't stop aging, but it can refresh the face. A procedure once seemingly reserved for older generations, now younger patients, especially in Gen X, are reportedly increasingly using it to stay ahead of visible aging. The rising popularity of the facelift may be because of GLP-1 medications, such as Ozempic®. The rapid weight loss brought on by these drugs can deplete volume in the face, leading some patients to seek a facelift to restore a more youthful appearance.

Aesthetic Trend:
(Weight) Loss and Lifts

Lifts and tucks had a standout year in 2024 as plastic surgery continued to evolve alongside a growing wave of patients seeking to complete their weight loss journeys. The use of GLP-1 medications like Ozempic® and Wegovy® accelerated this trend, creating new conversations about proportion, skin elasticity and body contouring procedures following substantial weight loss.

837,485 patients
were prescribed GLP-1 weight loss medications by ASPS Member Surgeons.

Abdominoplasty, or tummy tuck, was the third most popular cosmetic surgery procedure in 2024, with 171,064 procedures performed. Similarly, breast lifts held strong with 153,616 surgeries, while lower body lifts, thigh lifts and buttock lifts each saw modest but meaningful increases. These procedures directly address excess or sagging skin, a common and often emotionally complex side effect of rapid weight loss through GLP-1 medications. Lifts are contouring tools, not weight loss procedures, and as more individuals reach their desired goals, they may increasingly explore lifts and tucks to help provide the finishing touches to their physiques.

While female patients tend to dominate plastic surgery statistics, it is also interesting to note that in 2024, 10% of lower body lift patients and 5% of thigh lift patients were male. In 2023, statistics show that males only comprised 5% of lower body lift patients and 3% of thigh lift patients. As more people become interested in taking GLP-1 medications for weight loss, more men may be interested in pursuing lifts to address weight loss-related body concerns.

Additionally, the 2024 statistics show that while only 20% of patients on GLP-1 medication have already undergone plastic surgery as a result of weight loss from GLP-1 use, an astounding 41% of those prescribed GLP-1 medications for weight loss are considering nonsurgical procedures and 39% are considering surgical procedures, perhaps setting up an interesting trend to watch in 2025.

Understanding the New Class of Weight-Loss Medications

GLP-1 medications have been used for more than a decade to help treat patients diagnosed with type 2 diabetes. One of the side effects many diabetic patients reported to their doctors was increased weight loss. By 2021, the U.S. Food and Drug Administration (FDA) approved the first semaglutide drug specifically for use as a weight-loss medication after some physicians had been prescribing it off-label due to its weight-loss results. Today, numerous GLP-1 medications, such as Ozempic®, Wegovy®, Mounjaro®, Zepbound® and compounded drugs, are competing for the weight loss spotlight.

Semaglutide and tirzepatide are the “active” ingredients of many of these weight-loss medications. They mimic the naturally occurring hormone that promotes insulin production to reduce blood-sugar levels. In certain quantities, the specific hormone also interacts with the brain to suppress appetite by signaling that a person feels full. In addition to suppressing appetite, these weight-loss medications also work by slowing digestion, increasing the time it takes for food to digest and leave the body. One study published in the *Journal of American Medicine* suggests that after three months, individuals on a semaglutide treatment lost 5.9% of their total body weight, and 10.9% at six months. The explosion in interest in GLP-1 weight-loss medications may be spurring new groups of individuals to examine their plastic surgery options in relation to improved proportionality.

Aesthetic Trend:
(Weight) Loss and Lifts *(Continued)*

Why Lifts?

GLP-1 medications work by suppressing appetite and slowing digestion, often leading to significant and rapid weight loss. However, the body doesn't always respond uniformly. Patients frequently find they can't control where fat is lost, resulting in uneven volume reduction—particularly in the face, chest or limbs. Additionally, rapid weight loss doesn't allow the skin adequate time to contract and reshape as gradual weight loss might, often leading to sagging or loose skin. The term "Ozempic face" has gained popularity to describe the hollowed appearance some individuals experience due to facial fat loss.

As a result, lifts have become an increasingly popular option for patients looking to address excess skin following GLP-1-related weight loss. Procedures such as thigh, buttock, lower body, arm and neck lifts can help restore contour and remove skin that has not retracted due to the pace or extent of fat loss. These procedures not only refine physical appearance but can also improve comfort and mobility.

Sagging skin can impede psychological progress by making it difficult to "size down" for many patients and purchase clothing that helps them showcase their results. With excess skin, patients may have to wear the same size clothing as before their weight-loss results. Lifts can help remove excess skin, enhancing mental wellness and physical mobility, offering the proportionality patients are seeking and removing concerns of chaffing and rashes. It also improves their quality of life, and they are better able to move forward mentally and physically.

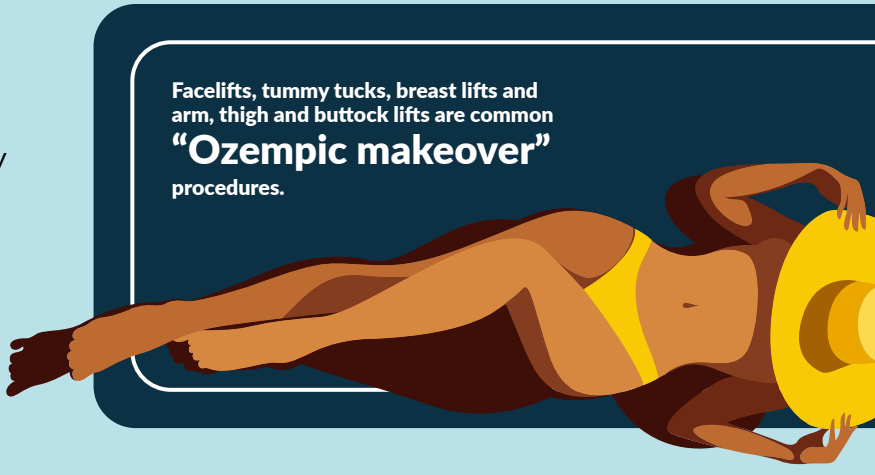
Another recently coined phrase, the "Ozempic makeover" is a customizable set of plastic surgery procedures that aims to address facial and body changes brought on by significant weight loss. The goal is to help patients feel comfortable in their new bodies and address specific weight loss-related concerns like excess skin, sagging breasts, stubborn fat pockets and facial volume loss. Facelifts, tummy tucks, breast lifts and arm, thigh and buttock lifts are common "Ozempic makeover" procedures.

Weight loss medications may make lifts more appealing and accessible to more people. Since lifts are a sculpting procedure, a patient must be within reach of their goal weight to be eligible for surgery. Thanks to nutrition, exercise and semaglutide GLP-1 medications, access and interest in contouring procedures may increase as more individuals reach their weight-loss goals and look for aesthetic solutions to achieve physical and mental wellness. Access to dieticians, personal trainers and other medical professionals such as plastic surgeons can also help support patients on their journey.

Plastic Surgery Considerations

Combining plastic surgery procedures with significant weight-loss results from GLP-1 medications can relieve excess skin discomfort that causes irritation and chaffing, reshape and contour the body and improve self-esteem and confidence. However, it is not medically advisable to combine GLP-1 medications and surgery. Individuals interested in plastic surgery should understand that they'll usually be required to discontinue the use of any GLP-1 medication before any plastic surgery procedure.

Surgeons and anesthesiologists generally recommend that a patient stop GLP-1 weight loss medication at least two to three weeks before surgery. Again, these medications work partially by slowing digestion. When the stomach stays



Aesthetic Trend:
(Weight) Loss and Lifts *(Continued)*

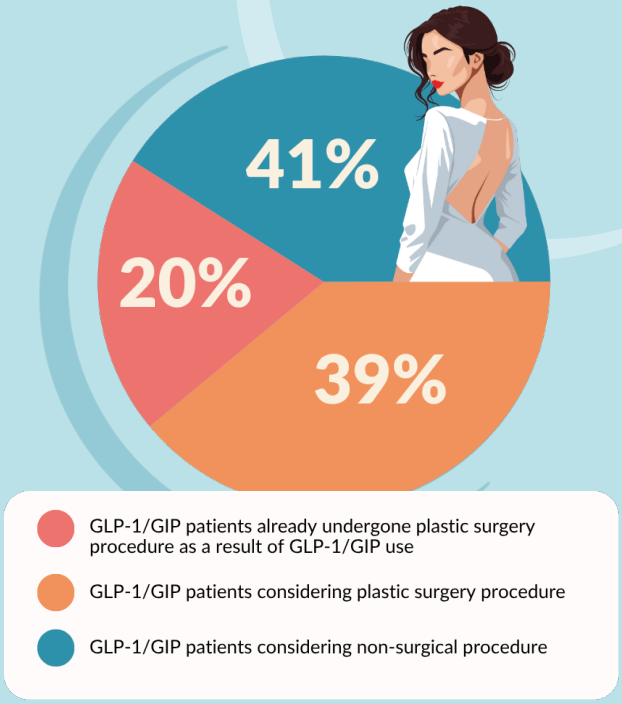
fuller for longer, there is the potential that undigested food remains in the stomach before surgery, increasing a patient's risk for aspiration while they are under anesthesia. Aspiration occurs when stomach contents are inhaled into the lungs, which can be a serious and potentially life-threatening complication.

Patients may also be asked to stop taking their weight-loss medication for a time after surgery to increase their nutritional intake. GLP-1 drugs can delay the body's ability to process nutrients crucial to wound healing and recovery. Some plastic surgeons recommend discontinuing weight-loss medications while increasing protein and fluid intake during recovery.

Increasing protein intake and focusing on weight training and muscle mass before surgery is also indicated to help with post-surgery recovery and maximize a patient's aesthetic results.

Conclusion

GLP-1 medications seem like the long-awaited "magic bullet" of weight loss. As the weight comes off, it can be easier to incorporate habits like exercise and nutrition into an overall healthier lifestyle that enhances physical and mental well-being. Combined with specific and personalized body contouring procedures, a proportional aesthetic may be more attainable than ever. Still, an individual should never take it without the guidance and support of a medical professional who can help a patient understand the potential side effects and make lifestyle adjustments to help them avoid "boomerang" weight gain.



New data indicates that 20% of patients on GLP-1 medication have already undergone a plastic surgery procedure due to their medication-induced weight loss. Time will tell if the popularity of weight-loss medications translates into even greater gains in specific plastic surgery procedures.

Surgeons and anesthesiologists generally recommend that a patient stops GLP-1 weight loss medication at least two to three weeks before surgery.

2024 Minimally Invasive Procedures

COSMETIC MINIMALLY INVASIVE PROCEDURES*	2024	2023	% CHANGE 2024 vs 2023
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	**9,883,711**	9,480,949	4%
Lip augmentation (with injectable materials)‡	**1,449,565**	1,439,291	1%
Noninvasive fat reduction (e.g., CoolSculpting®, Liposonix®, Emsculpt®, Vanquish®, Zerona®, Kybella®)	**447,581**	745,967	-40%
Nonsurgical skin tightening (e.g., Pelleve®, Thermage®, Ulthera®)	**439,032**	438,211	0%
Sclerotherapy	**516,883**	515,602	0%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microdermabrasion)	**3,703,305**	3,501,696	6%
Skin treatment using lasers (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	**3,112,056**	3,101,772	0%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	**5,331,426**	5,294,603	1%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	**932,861**	924,549	1%
HA fillers for lip augmentation (with injectable materials)‡**	**1,589,502**		
Prescribed weight loss medication (e.g., semaglutide, tirzepatide)**	**837,485**		
TOTAL	**28,243,407**	**25,442,640**	**1.5%**

*** All procedures include data from ASPS members as well as non-member dermatologists and otolaryngologists.*

‡ "Lip Augmentation with HA Filler" was collected as a distinct procedure for the first time in 2024. In prior years, these procedures may have been reported under "Lip Augmentation with Injectable Materials." The two categories should not be combined due to potential overlap and risk of double counting.

Top 5
Cosmetic Minimally Invasive Procedures for 2024

1

Neuromodulator Injections

These wrinkle-relaxing injections such as Botox® are a smooth operator that iron out fine lines with little downtime, acting like a real-life beauty filter for the face. This treatment saw a 4% rise in 2024, showing they remain the go-to treatment patients can't do without. It's also remained a favorite for decades because of its affordability.

2

Soft Tissue Fillers/Hyaluronic (HA) Acid Fillers

These injections act like a reboot button for your face, making them another long-time favorite treatment. HA fillers help add volume and fullness, offering patients the perfect plump and youthful aesthetic. Customizable to a patient's specific needs and requiring minimal downtime and instant results, it is no wonder HA fillers continue to remain popular on social media and the top five list.

3

Skin Resurfacing

Lasers help with hitting the reset button on your complexion. Chemical peels and dermabrasion zap damaged skin to reveal a fresh, radiant layer beneath. Skin resurfacing jumped in 2024, rising 6%. The data showed more patients are turning to these treatments to bring their inner glow to the outside.

4

Skin Treatments

Minimize skin imperfections with treatments such as laser hair removal, laser skin resurfacing and Intense Pulsed Light (IPL) therapy. These treatments tackle a wide variety of concerns, ranging from sun damage, fine lines and hyperpigmentation. The skin is the human body's largest organ, so it makes sense that these treatments are among the most popular.

5

Lip Augmentation

Lip augmentation has seen continuous year-over-year growth and has remained in the top five since ASPS began tracking it in 2022. These injections enhance lip volume, shape and symmetry for a customized treatment that will leave you grinning from ear to ear.

Trend to Watch: Non-Hyaluronic Acid Fillers

Non-hyaluronic acid (non-HA) fillers like Radiesse®, Sculptra®, Bellafill® and Renuva® received honorable mention in the top minimally invasive treatments category. Steady year-over-year demand means more patients are taking notice and are interested in the results that can be achieved with non-HA fillers. They are not as dissolvable as soft tissue or HA fillers, but they can offer longer-lasting results.

Minimally Invasive Trend:
Incredible Injectables

Plastic surgery is a rapidly changing medical specialty, but some treatments are not just "trends" – and for a good reason. Injectables continue to dominate minimally invasive procedures. The 2024 statistics indicate an overall 1.5% increase in minimally invasive injectable treatments, well over the 1% increase seen in surgical cosmetic procedures. Why are these treatment options outpacing surgery? It's more than celebrity influence and social media trends.

Many patients may have seen minimally invasive treatments as a more affordable way to keep looking their best while adding a touch of glamor and luxury to their lifestyle. They also remain popular because injectables can help patients achieve a more "natural" aesthetic, giving them a refreshed look that remains relatively undetectable as a plastic surgery treatment.

In addition to the other benefits, such as minimal downtime, a quick turnaround and the ability to try a new look without a long-term commitment, injectables undoubtedly continue to deliver the type of results that individuals are looking for without breaking the bank.

It's Not in the Eyes, It's in the Lips

Some say that the eyes are the first things they notice about a person when meeting them for the first time. However, lip augmentation numbers may tell a different story. Since ASPS started tracking lip augmentation data three years ago in 2022, the procedure has stayed in the top five of minimally invasive procedures. Partly due to the popularity of HA fillers, and partially due to the accessibility and affordability of the procedure, lip augmentation is one procedure that can help create the perfect pout, define lip shape, reduce fine lines and correct lip asymmetries.

Botox®: King of Injectables

Neuromodulator injections, such as Botox®, remain the undisputed "king" of minimally invasive procedures. 9,883,711 patients diminished the look of fine lines and wrinkles with neuromodulator injections in 2024, growing 4% from 2023 numbers. These age-diminishing injectables have proven to be a consistent favorite for two decades, and for a good reason. A more affordable alternative to surgical procedures like a facelift or blepharoplasty, neuromodulator injections still deliver reliable, age-defying results in a more nuanced and natural way by temporarily relaxing facial muscles.

New additions to the neuromodulator injection market, like Letybo®, approved by the FDA in February 2024 to treat frown lines between the eyes, and Daxxify®, approved in 2023, are giving patients more options than ever before. More competition in the neuromodulator injection market doesn't just mean that patients have more options to address their skin concerns. More competition can mean more competitive prices. In this increasingly budget-conscious economy, savvy shoppers with more choices may help them stretch their dollar further.

Minimally Invasive Trend:
Incredible Injectables *(Continued)*

The Perfect Plump with Soft Tissue HA Fillers

Soft tissue or HA fillers are the second most popular minimally invasive treatment in 2024. HA fillers help add volume and fullness, typically in the cheeks and lips. Hyaluronic acid is a naturally occurring substance found in high concentrations in the human body's soft connective tissues and the fluid surrounding the eyes. HA fillers, using a synthetic form of hyaluronic acid, plump areas that need a volume boost. They can also smooth fine lines and wrinkles and help contour facial features.

While some point to articles and social media trends calling out "filler fatigue," the weariness associated with HA fillers, or uncanny puffiness related to an overfilled face, soft tissue filler remains an extremely popular minimally invasive procedure. In 2024, 5,331,426 patients opted to round out their appearance with HA fillers, a 1% increase over the previous year. Statistics also show that soft tissue fillers remain popular with those 40-54, who account for 50% of patients undergoing the procedure. Filler and fat grafting procedures may potentially increase to address "Ozempic face" concerns stemming from rapid weight loss.

Minimally invasive procedures continue to make their mark. While they offer some significant advantages over surgical procedures, like minimal downtime, affordability and more immediate results, patients still need to take the time to plan accordingly and prepare for what to expect after a procedure.

Not all minimally invasive treatments offer instantaneous results. Depending on the neuromodulator injections, it can take anywhere from 24 hours to three to five days to see noticeable results. By contrast, HA filler results may not be apparent for two to four weeks on average. The body is amazing, but still needs time to heal, even after minimally invasive procedures. There is no need to panic if, after one day, you still see bruising or swelling.

For the best results from minimally invasive procedures, schedule your treatment well before significant events or milestones and always see an ASPS Member Surgeon or a qualified injector overseen by an ASPS Member Surgeon.

In 2024,
5,331,426 patients
used HA filler to round out their appearance.

2024 Reconstructive Procedures

RECONSTRUCTIVE SURGERY PROCEDURES	2024	2023	% CHANGE 2024 vs 2023
Breast implant removal (reconstructive patients only)	**26,600**	25,221	5%
Breast reconstruction	**162,579**	157,740	3%
Burn care	**24,256**	23,867	2%
Cleft lip and palate repair	**13,488**	12,918	4%
Hand surgery (e.g., carpal tunnel, arthritis, trigger finger)	**208,480**	207,887	0%
Head and neck reconstruction (including microsurgical)	**21,875**	21,618	1%
Hernia repair	**13,211**	13,091	1%
Laceration repair (other than facial)	**45,701**	45,575	0%
Liposuction for lipedema *only*	**29,644**		
Lower extremity reconstruction (including microsurgical)	**21,668**	21,427	1%
Maxillofacial	**54,747**	52,868	4%
Pelvic floor reconstruction	**3,737**	3,643	3%
Pressure ulcers	**16,912**	16,453	3%
Scar revision	**54,280**	52,000	4%
Treatment of dog bites	**19,202**	19,201	0%
Tumor removal (including skin cancer)	**361,798**	351,591	3%
TOTAL	1,048,534	1,025,100	2%

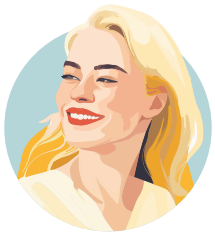
*** Counts of procedures performed by ASPS Member Surgeons only.*

Top 5
Reconstructive Procedures for 2024

1

Tumor Removal

Tumor removal remains the top reconstructive surgery procedure year after year. It involves surgically removing abnormal growths, either benign masses or cancerous tumors, such as skin cancer. Tumor removal is more than aesthetic. It addresses significant health concerns for patients and can lead to improved mental and physical well-being.



2

Hand Surgery

For the second consecutive year, hand surgery is the second most performed reconstructive procedure performed by plastic surgeons. It encompasses specialized procedures that address numerous health conditions that impact mobility, range of motion and pain in the hand, wrist and forearm, such as trauma, repetitive stress injuries like carpal tunnel and arthritis.

3

Breast Reconstruction

Breast reconstruction is among the top five reconstructive procedures for a third straight year, with a 3% increase in patients since 2023. Breast reconstruction helps restore the shape and contours of the breast after a mastectomy, lumpectomy or other breast surgery. The variety of surgical techniques and innovative implants on the market allow a board-certified plastic surgeon on a patient's medical team to help increase options and offer the best aesthetic outcome possible for their situation.

4

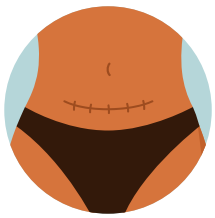
Maxillofacial

With a 4% increase over last year's numbers, maxillofacial procedures are once again in the top five reconstructive procedures. Maxillofacial surgeries aim to improve the face or jaw's form, function and appearance, restoring a patient's ability to speak, chew and breathe and giving a renewed sense of confidence.

5

Scar Revision

Addressing both cosmetic and functional concerns, scar revision helps minimize the appearance of scars caused by injury, surgery or trauma, blending them more seamlessly with surrounding skin. Up 4% from 2023, this reconstructive procedure can also relieve discomfort and restore mobility when scar tissue restricts movement, improving physical function and supporting emotional well-being.



Reconstructive Feature:
Fangs on Flesh: How Plastic Surgeons Help Heal Dog Bites

Dogs may be our most cherished loyal companions, but even a trusted pet can bite under certain circumstances. The damage done can be serious, especially to the face, hands or limbs. The 2024 statistics showed over 19,200 people had reconstructive procedures for dog bites.

Most dogs are not aggressive, but bites can happen in a split second and without warning. Any dog can bite if provoked. It's not about a dog's breed or size, but its individual history and behavior. In fact, half of dog bites come from household pets.

A crucial step to getting the best outcome is placing a plastic surgeon on a care team early, shortly after a dog bite occurs. Collaboration with an ASPS Member Surgeon helps patients understand and evaluate the full range of options based on their specific situation. A plastic surgeon can explain what treatments are available and what aesthetic results are possible while supporting the patient's mental well-being.

A Unique Skillset for a Challenging Injury

There's no typical type of dog bite. Each case is different. Dogs often clamp down with their mouths with remarkable force and can then whip their heads around. Dog bites leave a range of injuries including puncture wounds from teeth, tearing from the movement, deep cuts, crushed bones, partially or completely torn off features, or a combination of these injuries. Bites can also injure tendons, ligaments and nerves. These injuries can leave significant scars and limit movement if not correctly treated.

Children, especially those who are younger, face the highest risk of serious injury as their short stature puts them face-to-face with dogs. Younger children may also lack the motor skills or fear of dogs to move away from danger. Facial features such as the lips, nose and ears of children are especially vulnerable to bites because children are often about the same height as dogs. Dogs can easily latch on to those sensitive facial features. Conversely, adults tend to have more hand and leg injuries from dogs. Hand injuries often happen because a child or adult is holding something a dog wants, such as food or a toy.

It's important that children who suffer dog bites see pediatric face and hand specialists early to get the best long-term results since they are still growing. A plastic surgeon will be able to restore both the appearance and functionality of the injured area in a patient of any age. That's because plastic surgeons have an advanced understanding of soft tissues, the structure of the skin and how it connects to other tissues. They also can have more experience in repairing severely damaged anatomy or sections of skin because the specialty often pioneers new medical techniques.

Act Fast: Early Medical Care Matters

Treating dog bites immediately and correctly leads to better aesthetic and functional healing. Social media advice is no substitute for expert medical care. It's important to get a bite check right away, even if it doesn't look serious.

Bites need to be properly cleaned to prevent infection from the bacteria that live in dogs' mouths. Additionally, a rabies shot might be needed if the dog's vaccination status can't be determined. These actions will help reduce complications that may affect healing.

Next, an ASPS Member Surgeon can help heal or rebuild the injuries once the wounds are stabilized. Successful aesthetic results don't only depend on the skin healing well but may also be affected by the repair of deeper tissues. This might include reattaching body parts including skin, noses, lips or ears. Or those parts may need to be reconstructed if they can't be recovered.

Bites often occur in areas with delicate, interwoven structures. These procedures can involve a complicated network of blood vessels, tendons, nerves, bones and joints. A plastic surgeon can guide healing so results resemble the pre-injury appearance as closely as possible.

Some injuries will require more than one procedure. Sometimes, several staged operations or additional

Reconstructive Feature:

Fangs on Flesh: How Plastic Surgeons Help Heal Dog Bites *(Continued)*

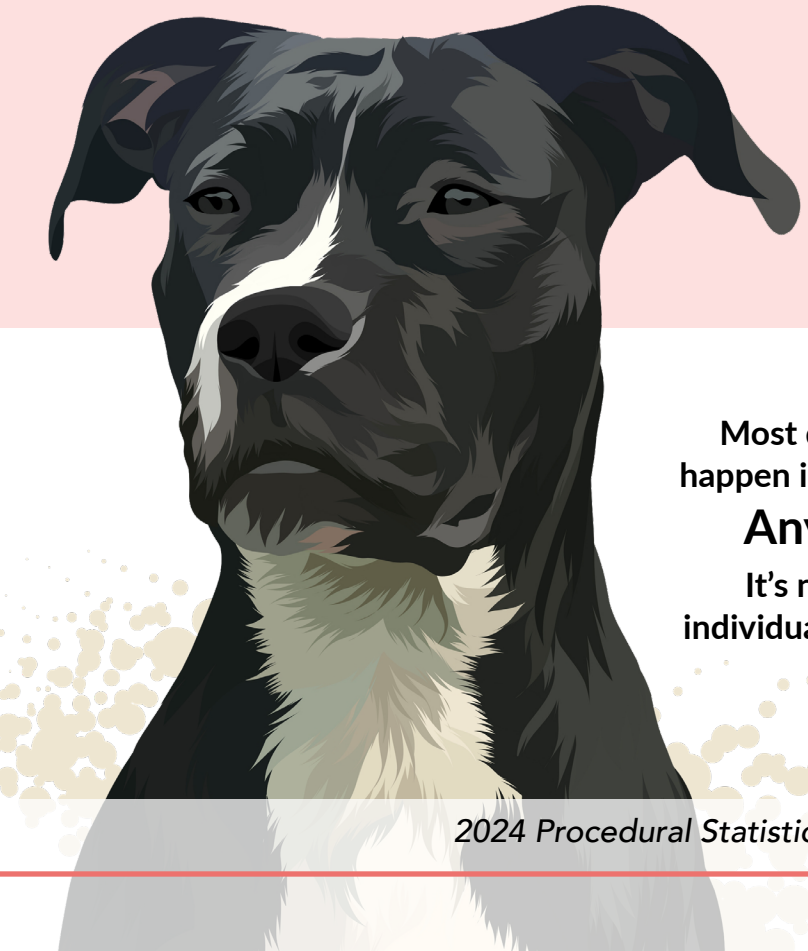
minimally invasive treatments will be needed. Scar revision can also be an option.

Bites Leave Both Physical and Emotional Scars

Trauma can also be a factor in dog bite cases. Families are often distraught because many bites come from a beloved family pet. Sometimes, it is the first time the animal has shown any type of aggressive behavior. There can also be trauma long after the bite, especially when someone needs to explain a facial difference.

Plastic surgeons will not only focus on repairs and reconstruction but will monitor a patient's mental health and direct them to resources, if necessary. They are trained to restore form and function, meaning they help patients not only heal physically but also recover their appearance and confidence.

Plastic surgeons understand both the physical and mental scars a dog bite can leave. They treat the whole patient, not just the injury.



Most dogs are not aggressive, but bites can happen in a split second and without warning.

Any dog can bite if provoked.

It's not about a dog's breed or size, but its individual history and behavior. In fact, half of dog bites come from household pets.

2024 COSMETIC SURGERY AGE DISTRIBUTION (19 AND UNDER‡)	AGE 19 AND UNDER‡ 2024 TOTAL	AGE 19 AND UNDER‡ % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	**2,774**	1%
Breast implant removals (augmentation patients only)**	**13**	0%
Breast lift (mastopexy)**	**1,169**	1%
Breast reduction (aesthetic patients only)**	**5,325**	7%
Breast reduction in males (gynecomastia surgery)**	**2,942**	11%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	**123**	0%
Buttock augmentation with fat grafting**	**62**	0%
Buttock implants**	**9**	1%
Buttock lift**	**0**	0%
Labiaplasty**	**355**	3%
Liposuction	**3117**	1%
Lower body lift**	**17**	0%
Thigh Lift**	**9**	0%
Upper arm lift (brachioplasty)**	**9**	0%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	**315**	3%
Chin augmentation (mentoplasty)**	**408**	7%
Ear surgery (otoplasty)**	**1,706**	35%
Eyelid surgery (blepharoplasty)**	**95**	0%
Facelift (rhytidectomy)**	**27**	0%
Facial fat grafting**	**16**	0%
Forehead lift**	**25**	0%
Neck lift**	**22**	0%
Nose reshaping (rhinoplasty)**	**4,810**	10%
PROCEDURE TOTALS	**23,348**	**1%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	28,685	0%
Sclerotherapy	777	0%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	6,127	0%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	211,317	7%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	9,528	0%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	6,908	1%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**263,342**	**1%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

‡ While patients under the age of 18 may access plastic surgery procedures under physician guidance and with the approval of a parent or guardian, this is atypical compared to the overall patient experience and the majority of cases within this data set are focused on the ages 18 to 19 years.
Maturity – Adolescents typically experience changes in perception of body image, so it is important to assess the stability of each individual's self-image before proceeding with plastic surgery. There are four attributes associated with body image that should be considered. These include physical reality of the appearance, perceptions of appearance, importance of appearance and the degree of satisfaction with appearance.
In addition, adolescents may not have the physical and/or emotional maturity to choose plastic surgery. They may have unrealistic expectations about the surgery itself or about the outcome. They also may not understand that additional surgery may be necessary because of complications or a change in personal desire. Finally, they may not have reached full physical development.
Informed Consent – It is important that the adolescent patient completely understand the procedure, possible complications and likelihood for additional procedures at some future date. As with all cosmetic procedures, appropriate informed consent will be required. The education process associated with an informed consent should help the patient and the parent/guardian understand the risks, benefits and potential complications associated with the procedure.

2024 COSMETIC SURGERY AGE DISTRIBUTION (20-29)	AGE 20-29 2024 TOTAL	AGE 20-29 % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	49,277	16%
Breast implant removals (augmentation patients only)**	1,189	3%
Breast lift (mastopexy)**	9,609	6%
Breast reduction (aesthetic patients only)**	15,458	20%
Breast reduction in males (gynecomastia surgery)**	7,417	28%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	5,992	4%
Buttock augmentation with fat grafting**	4,373	15%
Buttock implants**	175	14%
Buttock lift**	344	4%
Labiaplasty**	2,551	24%
Liposuction	27,785	8%
Lower body lift**	467	4%
Thigh Lift**	206	2%
Upper arm lift (brachioplasty)**	672	3%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	2,046	22%
Chin augmentation (mentoplasty)**	1,632	30%
Ear surgery (otoplasty)**	1,008	21%
Eyelid surgery (blepharoplasty)**	458	0%
Facelift (rhytidectomy)**	379	0%
Facial fat grafting**	393	1%
Forehead lift**	196	1%
Neck lift**	33	0%
Nose reshaping (rhinoplasty)**	12,782	26%
PROCEDURE TOTALS	**144,442**	**9%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	142,907	1%
Sclerotherapy	22,544	4%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	6,140	0%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	631,318	20%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	141,993	3%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	30,395	3%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**975,297**	**3%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 COSMETIC SURGERY AGE DISTRIBUTION (30-39)	AGE 30-39 2024 TOTAL	AGE 30-39 % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	112,500	37%
Breast implant removals (augmentation patients only)**	7,370	18%
Breast lift (mastopexy)**	40,028	26%
Breast reduction (aesthetic patients only)**	14,412	19%
Breast reduction in males (gynecomastia surgery)**	7,554	29%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	46,949	27%
Buttock augmentation with fat grafting**	11,613	39%
Buttock implants**	430	35%
Buttock lift**	1,674	21%
Labiaplasty**	3,397	31%
Liposuction	91,067	26%
Lower body lift**	2,056	19%
Thigh Lift**	1,233	12%
Upper arm lift (brachioplasty)**	3,767	16%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	1,726	19%
Chin augmentation (mentoplasty)**	1,297	23%
Ear surgery (otoplasty)**	688	14%
Eyelid surgery (blepharoplasty)**	2,687	2%
Facelift (rhytidectomy)**	1,714	2%
Facial fat grafting**	1,546	5%
Forehead lift**	305	2%
Neck lift**	455	2%
Nose reshaping (rhinoplasty)**	11,413	24%
PROCEDURE TOTALS	**365,881**	**23%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	1,820,496	18%
Sclerotherapy	76,880	15%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	115,874	3%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	917,654	29%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	608,379	11%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	87,921	9%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**3,627,204**	**13%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 COSMETIC SURGERY AGE DISTRIBUTION (40-54)	AGE 40-54 2024 TOTAL	AGE 40-54 % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	100,695	33%
Breast implant removals (augmentation patients only)**	17,494	42%
Breast lift (mastopexy)**	66,362	43%
Breast reduction (aesthetic patients only)**	24,381	32%
Breast reduction in males (gynecomastia surgery)**	5,572	21%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	84,328	49%
Buttock augmentation with fat grafting**	11,417	39%
Buttock implants**	543	44%
Buttock lift**	4,371	55%
Labiaplasty**	3,655	34%
Liposuction	156,325	45%
Lower body lift**	5,751	52%
Thigh Lift**	5,059	51%
Upper arm lift (brachioplasty)**	9,809	42%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	3,150	35%
Chin augmentation (mentoplasty)**	888	16%
Ear surgery (otoplasty)**	668	14%
Eyelid surgery (blepharoplasty)**	30,384	25%
Facelift (rhytidectomy)**	14,514	18%
Facial fat grafting**	7,260	21%
Forehead lift**	2,976	22%
Neck lift**	4,553	20%
Nose reshaping (rhinoplasty)**	12,664	26%
PROCEDURE TOTALS	**572,819**	**36%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	5,623,400	57%
Sclerotherapy	233,108	45%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	728,843	20%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	1,093,794	35%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	2,679,179	50%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	435,315	47%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**10,793,639**	**38%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 COSMETIC SURGERY AGE DISTRIBUTION (55-69)	AGE 55-69 2024 TOTAL	AGE 55-69 % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	**35,627**	12%
Breast implant removals (augmentation patients only)**	12,722	31%
Breast lift (mastopexy)**	32,006	21%
Breast reduction (aesthetic patients only)**	15,551	20%
Breast reduction in males (gynecomastia surgery)**	2,426	9%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	30,651	18%
Buttock augmentation with fat grafting**	1,958	7%
Buttock implants**	88	7%
Buttock lift**	1,418	18%
Labiaplasty**	770	7%
Liposuction	64,289	18%
Lower body lift**	2,488	23%
Thigh Lift**	3,145	32%
Upper arm lift (brachioplasty)**	7,910	34%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	1,418	16%
Chin augmentation (mentoplasty)**	895	16%
Ear surgery (otoplasty)**	553	11%
Eyelid surgery (blepharoplasty)**	67,559	56%
Facelift (rhytidectomy)**	46,446	59%
Facial fat grafting**	19,095	56%
Forehead lift**	7,989	59%
Neck lift**	13,372	60%
Nose reshaping (rhinoplasty)**	5,887	12%
PROCEDURE TOTALS	**374,263**	**24%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	2,268,223	23%
Sclerotherapy	171,975	33%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	2,246,597	61%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	257,973	8%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	1,892,347	35%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	372,322	40%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**7,209,437**	**26%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 COSMETIC SURGERY AGE DISTRIBUTION (70+)	AGE 70+ 2024 TOTAL	AGE 70+ % of TOTAL PROCEDURES
COSMETIC SURGICAL PROCEDURES – BREAST		
Breast augmentation (implant placement for both primary and/or revisions)**	5,323	2%
Breast implant removals (augmentation patients only)**	2,483	6%
Breast lift (mastopexy)**	4,442	3%
Breast reduction (aesthetic patients only)**	1,607	2%
Breast reduction in males (gynecomastia surgery)**	519	2%
COSMETIC SURGICAL PROCEDURES – BODY		
Abdominoplasty (tummy tuck)**	3,021	2%
Buttock augmentation with fat grafting**	43	0%
Buttock implants**	0	0%
Buttock lift**	147	2%
Labiaplasty**	99	1%
Liposuction	7,145	2%
Lower body lift**	178	2%
Thigh Lift**	262	3%
Upper arm lift (brachioplasty)**	1,360	6%
COSMETIC SURGICAL PROCEDURES – FACE		
Cheek implant (malar augmentation)**	475	5%
Chin augmentation (mentoplasty)**	409	7%
Ear surgery (otoplasty)**	202	4%
Eyelid surgery (blepharoplasty)**	19,572	16%
Facelift (rhytidectomy)**	15,978	20%
Facial fat grafting**	5,950	17%
Forehead lift**	2,130	16%
Neck lift**	4,010	18%
Nose reshaping (rhinoplasty)**	867	2%
PROCEDURE TOTALS	**76,222**	**5%**
COSMETIC MINIMALLY INVASIVE PROCEDURES		
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	---	---
Sclerotherapy	11,599	2%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microderm-abrasion)	599,724	16%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	---	---
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Restylane®)	---	---
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	---	---
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**611,323**	**2%**

** *Counts of procedures performed by ASPS Member Surgeons only.*

Plastic Surgery Across the Generations

Surgical cosmetic procedures were once regarded as being the domain of "older" adults. Innovative techniques, minimally invasive treatment options and a broader media footprint have made plastic surgery more of interest to a wider – and younger – audience. Famous faces and stars of the silver screen aren't the only ones offering testimonials for plastic surgery. Social media has helped bring plastic surgery procedures to younger patients and started reshaping the generational landscape. The 2024 statistics continue to reflect these generational trends.

Gen Z is Focusing on the Breasts and Face

For this report, those 20-29 are considered early Gen Z. This generation grew up with social media, cell phones and technological innovations at their fingertips, giving them access to beauty influencers like celebrities and individuals their own age sharing experiences with plastic surgery and aesthetic culture. Breast augmentation was the most popular surgical procedure for patients in this age group in 2024, with 49,277 procedures in total.

Minimally invasive procedures are also popular with members of Gen Z. The signature signs of aging, like crow's feet and wrinkles, may not be a concern for those in their 20s, but skin texture and appearance are, which is why skin treatments are at the top of the minimally invasive treatment list for this age group, accounting for over 631,000 procedures and 20% of the total for 2024. There may also be an increased focus on treating minor skin issues early to help prevent the need for more invasive treatments down the line.

Bust is a Must for Core Millennials

Like their younger counterparts, individuals in the 30-39 age range are also all about the face and bust. Core Millennials captured a significant portion of patients undergoing breast augmentation, representing 37% of the total number of patients choosing the plastic surgery procedure in 2024. In the minimally invasive category, these patients also leaned toward focusing on skin treatments, such as lasers, skin resurfacing and sclerotherapy – which treats varicose and spider veins – with 29% of the procedures performed.

The Bridge: Elder Millennials and Gen X Won't Be Forgotten

Individuals between 40-54 are both Elder Millennial and Gen X. Sometimes called the "Forgotten Generation" as they are sandwiched between the high-tech Core Millennials and one of the largest generational groups in U.S. history, the Baby Boomers. However, this bridge group on the ASPS report continues to flex its generational muscle and prove it won't be forgotten or overshadowed by the buying power of the Boomers or the Millennial influencers.

Lower body procedures are the focus of this generation, as statistics show buttock lifts, lower body lifts and thigh lifts are surging. The 2024 numbers indicate that 55% of buttock lift patients are 40-54. This age group also accounts

Plastic Surgery Across the Generations *(Continued)*

for 52% of lower body lift patients and 51% of thigh lift patients. The tummy tuck also remains popular with Gen X. Although numerous personal factors go into a plastic surgery decision, as this generation moves away from childbearing years, it is an increasingly strategic time to invest in self-care to tighten and tone areas that may have been affected by childbirth or the aging process.

Gen X makes up the most significant percentage of neuromodulator injection patients on the minimally invasive side. By targeting fine lines and wrinkles in their early stages, these patients are focusing efforts on slowing the visual signs of aging. They are also adding fullness and volume with hyaluronic acid fillers, and make up half (50%) of hyaluronic acid filler patients. These minimally invasive procedures don't just offer affordable and quick results; they may also help patients feel as if they can prolong the health and appearance of their skin as they age.

Baby Boomers Want to Put Their Best Face Forward

Patients in the 55-69 age group continue to focus on the face, prioritizing facial procedures such as the facelift, neck lift and forehead lift. In 2024, patients in the Baby Boomer age range made up more than half (59%) of all facelift patients, with 67,559 performed. The popularity of face, neck and forehead procedures indicates the continued interest in addressing the more pronounced signs of aging with the latest surgical techniques and aesthetics, which make many of these procedures virtually undetectable to family and friends.

Regarding minimally invasive treatment options, more Boomers are increasingly interested in skin resurfacing treatments, which can address specific skin concerns, discoloration and texture. In 2024, Boomers represented 61% of the patients undergoing skin resurfacing treatments.

Age may only be a number, but across the spectrum, patients at every stage of life want to look and feel confident. Although the focus of each age range may differ, more people recognize that at any age, it is okay to prioritize their aesthetic needs and desires.

55% of buttock lift patients are 40-54.

This age group also accounts for **52%** of lower body lift patients and 51% of thigh lift patients.

2024 AVERAGE SURGEON/PHYSICIAN FEES	2024
COSMETIC SURGICAL PROCEDURES – BREAST	
Breast augmentation (implant placement for both primary and/or revisions)**	$4,575-8,000
Breast augmentation with fat grafting only (no implants)**	$5,500-9,500
Breast implant removals (augmentation patients only)**	$3,650-6,500
Breast lift (mastopexy)**	$6,500-11,000
Breast reduction (aesthetic patients only)**	$7,000-12,500
Breast reduction in males (gynecomastia surgery)**	$5,000-9,000
COSMETIC SURGICAL PROCEDURES – BODY	
Abdominoplasty (tummy tuck)**	$8,000-13,500
Buttock augmentation with fat grafting**	$7,000-11,500
Buttock lift**	$7,000-11,500
Labiaplasty**	$3,550-6,500
Liposuction**	$4,300-7,500
Lower body lift**	$10,000-16,500
Thigh lift**	$7,000-12,000
Upper arm lift (brachioplasty)**	$6,000-10,500
COSMETIC SURGICAL PROCEDURES – FACE	
Buccal fat pad removal**	$3,000-5,500
Chin augmentation (mentoplasty)**	$4,000-6,000
Ear surgery (otoplasty)**	$4,500-7,500
Eyelid surgery (upper blepharoplasty)**	$3,000-5,500
Eyelid surgery (lower blepharoplasty)**	$3,709-6,500
Facelift (rhytidectomy)**	$12,000-19,000
Facial fat grafting**	$3,000-5,500
Forehead lift**	$4,000-7,500
Liposuction (submental/chin)**	$3,000-5,500
Neck lift**	$7,500-13,000
Nose reshaping (rhinoplasty)**	$7,500-12,500

ASPS has updated the presentation of surgeon fee data to reflect a projected range rather than a single price. This shift provides a more accurate representation of real-world conditions, recognizing the diverse geographic locations and practice settings of ASPS Member Surgeons across the country. The ranges represent an aggregate projection based on averages submitted by surveyed members.

*** Counts of procedures performed by ASPS Member Surgeons only.*

In a Slowed Economy, Patients Still Prioritized Aesthetic Health

The economy experienced slowed growth in 2024, and Americans faced concerns about stretching their dollars as much as possible. Post-COVID inflation remained sticky, leading to higher prices at grocery stores and for goods and services. Despite easing interest rates and slowly improving growth, consumer sentiment remained uncertain. The end of 2024 culminated with a presidential election, questions about the direction of the economy, and concerns about whether AI advancements would displace jobs. However, plastic surgery overall showed resilience in the face of more conservative spending by Americans.

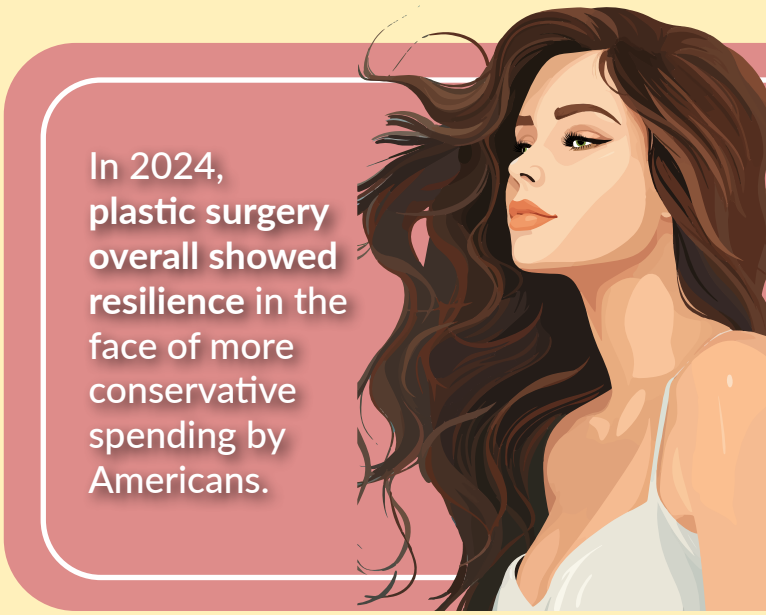
In times of economic uncertainty, Americans typically reduce spending or put off financing of larger purchases in anticipation of financial storms. The first things cut from household budgets are nearly always luxuries or nonessential items. But something slightly different happened in 2024. Statistics suggest that despite an unsure outlook, plastic surgery patients still prioritized their aesthetic health in their budgets.

The Demand for Plastic Surgery

Perhaps surprisingly, the 2024 statistics show that demand for plastic surgery procedures remained steady. No significant increases were noted, but the overall number of patients pursuing plastic surgery did not decrease year over year. Surgical plastic surgery procedures saw a modest 1% increase over 2023, while minimally invasive procedures were up approximately 3%.

Plastic surgery is still most popular with those who are 40-54, accounting for the majority at 38% of patients, and individuals 55-69, who account for 25%. These patients may have more financial stability and disposable income disposable income to invest in plastic surgery. They may also be more motivated to maintain a competitive edge in the workplace to better navigate a shifting job market with greater confidence.

Plastic surgery may be elective, but patients are still opting to undergo procedures that make them feel more confident and better able to tackle the challenges that an evolving economic landscape and career may bring. As more people experience worries about job security, downsizing and uncertainty in the workplace, they have expressed utilizing plastic surgery and minimally invasive procedures to keep a competitive edge.



In recent years, patients have opted to combine procedures in one setting to harness savings in terms of anesthesia costs, operating room fees and medical staff. That strategy has changed. Reports from ASPS Member Surgeons indicate that beginning in 2024, patients more and more requested a staged or strategic approach to their aesthetic goals. Keeping the end in mind, patients are working with their plastic surgeons to finance their plastic surgery journey and take it one step at a time paying as they go while still pursuing their final results.

In a Slowed Economy, Patients Still Prioritized Aesthetic Health *(Continued)*

Plastic Surgery by the Numbers

Some of the reasons for the continued popularity and growth of minimally invasive procedures are their cost and accessibility. Many patients consider minimally invasive procedures an affordable luxury or an essential part of their self-care routine.

Newcomers to the neuromodulator injection market, like Letybo® and Daxxify®, may also keep the cost of injectables competitive, meaning a potential for continued, steady demand for of these procedures. While "filler fatigue" grabbed headlines, lip augmentations with filler remained popular and has been since ASPS began tracking the procedure in 2022. Alongside both neuromodulators and lip augmentation, skin resurfacing similarly saw an increase in year-over-year demand. The continued popularity of each of these procedures indicates that patients still want to look and feel their best and are willing to invest in ongoing aesthetic maintenance to do so.

Beauty on a Budget

As economic headwinds remain top of mind for many well into 2025, it becomes imperative for patients who want to maintain their aesthetic with plastic surgery or explore their options to remain smart and safe. Plastic surgery carries real risks and potential health and aesthetic complications, and it is not the area to cut corners.

Be sure to always do your research and seek out ASPS Member Surgeons. In the long run, you may save money by reducing your risk of complications or needing expensive reconstruction or revision surgeries.

If you are interested in plastic surgery but concerned about the financial costs associated with a procedure, talk to your physician or their office staff for help. They can address your concerns and help you find solutions that fit your budget and aesthetic goals, whether it's a minimally invasive procedure as you save for something more significant or exploring financing options.

Should recent numbers be any indication, many individuals are not yet willing to give up their aesthetic luxuries and continue to include plastic surgery in their self-care regimens alongside other investments in physical and mental wellness. With responsible financial planning, plastic surgery and minimally invasive procedures may continue to be an investment patients prioritize as they wait for steadier economic times

The continued popularity of minimally invasive procedure indicates that patients still want to look and feel their best and are willing to invest in ongoing aesthetic maintenance to do so.

2024 COSMETIC SURGERY GENDER DISTRIBUTION (FEMALE)	2024 TOTAL PROCEDURES	2024 TOTAL FEMALE	% of TOTAL PROCEDURES	% CHANGE 2024 vs 2023
COSMETIC SURGICAL PROCEDURES – BREAST				
Breast augmentation (implant placement for both primary and/or revisions)**	306,196	304,334	99%	0.7%
Breast implant removals (augmentation patients only)**	41,271	41,180	100%	0.4%
Breast lift (mastopexy)**	153,616	153,278	100%	0.0%
Breast reduction (aesthetic patients only)**	76,734	74,495	97%	0.9%
Breast reduction in males (gynecomastia surgery)**	26,430	---	100%	---
COSMETIC SURGICAL PROCEDURES – BODY				
Abdominoplasty (tummy tuck)**	171,064	166,912	98%	0.5%
Buttock augmentation with fat grafting**	29,466	29,034	99%	0.3%
Buttock implants**	1,245	1,166	94%	0.9%
Buttock lift**	7,954	7,758	98%	2.7%
Labiaplasty**	10,827	10,827	100%	2.2%
Liposuction	349,728	328,646	94%	0.5%
Lower body lift**	10,957	9,862	90%	0.1%
Thigh Lift**	9,914	9,425	95%	3.3%
Upper arm lift (brachioplasty)**	23,527	23,082	98%	2.0%
COSMETIC SURGICAL PROCEDURES – FACE				
Cheek implant (malar augmentation)**	9,130	6,766	74%	3.4%
Chin augmentation (mentoplasty)**	5,529	4,312	78%	0.9%
Ear surgery (otoplasty)**	4,825	3,202	66%	0.1%
Eyelid surgery (blepharoplasty)**	120,755	105,404	87%	0.1%
Facelift (rhytidectomy)**	79,058	73,239	93%	0.8%
Facial fat grafting**	34,260	31,548	92%	0.1%
Forehead lift**	13,621	12,630	93%	0.8%
Neck lift**	22,445	19,672	88%	2.0%
Nose reshaping (rhinoplasty)**	48,423	41,405	86%	2.4%
PROCEDURE TOTALS	**1,585,878**	**1,458,177**	**94%**	**0.6%**
COSMETIC MINIMALLY INVASIVE PROCEDURES				
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	9,883,711	9,289,857	94%	4.2%
Sclerotherapy	516,883	488,574	95%	0.3%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microdermabrasion)	3,703,305	3,445,819	93%	5.7%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	3,112,056	2,623,375	84%	0.3%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Bolvella®, Restylane®)	5,331,426	5,184,475	97%	0.7%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	932,861	826,196	89%	0.9%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**28,243,407**	**21,858,296**	**93%**	**2.9%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 COSMETIC SURGERY GENDER DISTRIBUTION (MALE)	2024 TOTAL PROCEDURES	2024 TOTAL MALE	% of TOTAL PROCEDURES	% CHANGE 2024 vs 2023
COSMETIC SURGICAL PROCEDURES – BREAST				
Breast augmentation (implant placement for both primary and/or revisions)**	306,196	1,862	1%	1.1%
Breast implant removals (augmentation patients only)**	41,271	91	0%	0.0%
Breast lift (mastopexy)**	153,616	338	0%	0.0%
Breast reduction (aesthetic patients only)**	76,734	2,239	3%	1.1%
Breast reduction in males (gynecomastia surgery)**	26,430	26,430	100%	10.9%
COSMETIC SURGICAL PROCEDURES – BODY				
Abdominoplasty (tummy tuck)**	171,064	4,152	2%	1.0%
Buttock augmentation with fat grafting**	29,466	432	1%	0.5%
Buttock implants**	1,245	79	6%	1.3%
Buttock lift**	7,954	196	2%	2.6%
Labiaplasty**	10,827	---	0%	---
Liposuction	349,728	21,082	6%	1.0%
Lower body lift**	10,957	1,095	10%	0.4%
Thigh Lift**	9,914	489	5%	2.7%
Upper arm lift (brachioplasty)**	23,527	445	2%	2.3%
COSMETIC SURGICAL PROCEDURES – FACE				
Cheek implant (malar augmentation)**	9,130	2,364	26%	3.6%
Chin augmentation (mentoplasty)**	5,529	1,217	22%	0.6%
Ear surgery (otoplasty)**	4,825	1,623	34%	0.2%
Eyelid surgery (blepharoplasty)**	120,755	15,351	13%	-0.3%
Facelift (rhytidectomy)**	79,058	5,819	7%	0.4%
Facial fat grafting**	34,260	2,712	8%	0.1%
Forehead lift**	13,621	991	7%	0.8%
Neck lift**	22,445	2,773	12%	1.7%
Nose reshaping (rhinoplasty)**	48,423	7,018	14%	2.2%
PROCEDURE TOTALS	**1,585,878**	**98,798**	**6%**	**3.4%**
COSMETIC MINIMALLY INVASIVE PROCEDURES				
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	9,883,711	593,854	6%	4.3%
Sclerotherapy	516,883	28,309	5%	-0.2%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microdermabrasion)	3,703,305	257,486	7%	6.1%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	3,112,056	488,681	16%	0.3%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Bolvella®, Restylane®)	5,331,426	146,951	3%	0.7%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	932,861	106,665	11%	0.9%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**28,243,407**	**1,621,946**	**7%**	**2.7%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

Botox®, Blephs and Beyond:
More Men Are Investing in Their Aesthetic Health

Traditionally, women have dominated plastic surgery statistics. While that is still true to a degree, more men are becoming interested in looking and feeling better through cosmetic treatment. Plastic surgery is not the taboo subject that many once thought it was, and more patients than ever before are posting, blogging and video journaling their plastic surgery journey for all to see, adding credibility and visibility that is gaining the attention of more women and men, and empowering them to explore their own aesthetic journeys.

The numbers paint a picture of increasing awareness and potentially less stigma associated with men considering plastic surgery.

The Number of Men Seeking Plastic Surgery Results Increasing

Plastic surgery isn't just about looking better or advancing a career trajectory. The number of men getting plastic surgery to achieve their aesthetic goals is slowly but steadily increasing. The 2024 statistics suggest that 7% of all plastic surgery patients were men, a modest 1% increase over 2023. The numbers are telling because they paint a picture of increasing awareness and potentially less stigma associated with men considering plastic surgery as a viable option for their goals. In contrast, traditionally, plastic surgery was strongly associated with women.

While certainly less controversial or stigmatized thanks to social media and other trends, men's pursuit of cosmetic surgery may be a way to get a leg up in an uncertain economy. An increasingly competitive job market may be fueling renewed interest for men in aesthetic health because it offers an opportunity for men to improve their confidence.

Investing in one's aesthetic health may also help patients feel more confident and attractive in a world where there are fewer "third spaces" to organically meet friends and potential romantic partners. Online filter fatigue is a noted phenomenon, and if your photos don't match how you show up to a prospective date in real life, a love connection may end before it begins.

Breasts and Chests

Men and women are focusing on smaller, more athletic and proportional upper bodies. However, the athletic aesthetic looks different for men and women. For women, the top breast procedure remains breast augmentation. Yet, trends show that more women are opting for smaller and more proportional implants that offer just the right amount of cleavage. Breast lifts also remained steady in 2024, with 153,616 patients choosing the procedure, giving them more lift and shape.

For men, gynecomastia surgery, or male breast reduction, numbers increased compared to 2023, with a 2% rise in the number of men getting the procedure. Gynecomastia surgery has steadily seen an increase in men for the past several years, moving from 24,517 in 2023 to 26,430 patients in 2024.

The Eyes Have It

Men's and women's facial features are distinct. Most men are looking for a more sculpted and chiseled face with a masculine, defined jaw and chin, while women tend to prefer softer, fuller features that signal youth. The outcomes may differ, but both sexes are turning to plastic surgery

Botox®, Blephs and Beyond:

More Men Are Investing in Their Aesthetic Health *(Continued)*

to address the same concerns – the eyes.

Blepharoplasty, or eyelid surgery, was popular with men and women seeking to enhance the appearance of their eyes. Statistics show that 87% of patients undergoing the procedure were women. Ear surgery was even more popular with men, who made up 34% of patients choosing to focus on their ears. Men also sought chin augmentation and cheek implants, allowing them to sculpt and sharpen these facial features.

A Strong and Tight Core

Liposuction and tummy tucks are still overwhelmingly sought by women, with 98% of tummy tuck and 94% of liposuction patients being female. However, as GLP-1 weight loss medications gain in popularity with both sexes, liposuction and tummy tucks as part of an "Ozempic makeover" may start to change the numbers, giving men that hard-to-achieve V-shaped lower torso, and women a slim and more defined waist.

Minimally Invasive Treatments: The Affordable Way for Men and Women to Get Results Fast

Men and women are increasingly turning to minimally invasive treatment options as an affordable way to enhance their looks with minimal downtime. Neuromodulator injections, such as Botox®, Dysport®, Xeomin® and Jeuveau®, along with other newcomers to the market, are proving that the popularity of injectables among both sexes shows no signs of slowing. 2024 numbers show that 94% of neuromodulator patients were women and 6% were men looking to soften wrinkles and erase fine lines.

Men are discovering the benefits of neuromodulator injections to address signs of aging and build self-confidence without turning to surgical procedures. More men are also recognizing the benefits of skin care and self-care. These concepts go beyond traditional soap and water and include an interest in skin care products, treatments and minimally invasive procedures as a way to enhance their appearance and boost confidence socially and in the workplace.

Another popular noninvasive treatment for 2024 was skin treatments, which include laser hair removal, Intense Pulsed Light (IPL) treatments and laser tattoo removal. Laser skin treatments reached 3,112,056 patients, with 16% of those patients being men. A significant portion of plastic surgery patients who underwent enhancement with non-hyaluronic acid (non-HA) fillers were men at 11%, while HA fillers remained more popular for women.

Conclusion

More women may still be choosing the plastic surgery route, but men are slowly and surely adopting their own approaches to aesthetic care. Plastic surgery is for everyone because it gives equal opportunity to voice their concerns, make positive changes to their appearance and pursue aesthetic results that can help boost their confidence and mental wellness.

Men are discovering the benefits of **neuromodulator injections,** to address signs of aging and build self-confidence without turning to invasive surgical procedures.

2024 COSMETIC AND RECONSTRUCTIVE DEMOGRAPHICS

COSMETIC PROCEDURES PERFORMED IN	2024	% of 2024
Office	11,691,562	42%
Hospital	4,531,855	16%
Free-standing ambulatory surgical facility	11,481,756	41%
RECONSTRUCTIVE PROCEDURES PERFORMED IN	**2024**	**% of 2024**
Office	219,679	19%
Hospital	660,029	56%
Free-standing ambulatory surgical facility	289,885	25%

2024 COSMETIC AND RECONSTRUCTIVE DEMOGRAPHICS

BREAST AUG	2024	% of 2024
w/Breast Lift	79,921	26%
w/o Breast Lift	226,275	74%
TOTAL	**306,196**	

2024 RECONSTRUCTIVE BREAST PROCEDURES

RECONSTRUCTIVE PROCEDURES		2024	% of 2024
Timing	Immediate	120,963	74%
	Delayed	41,616	26%
Type	Tissue expander to implant	88,491	54%
	Direct to implant	37,744	25%
	Pedicle TRAM	1,139	1%
	Free TRAM	2,422	1%
	DIEP Flap	21,391	13%
	Latissimus Dorsi Flap	5,532	3%
	Other Free Flap	5,860	4%
Acellular Dermal Matrix		82,442	51%
Position	Prepectoral	109,758	68%
	Subpectoral	52,821	32%
TOTAL		**162,579**	

All figures are projected.

**Breast reconstruction procedures are more often for congenital and developmental breast deformities rather than cancer reconstruction.*

† While patients under the age of 18 may access plastic surgery procedures under physician guidance and with the approval of a parent or guardian, this is atypical and the majority of cases within this data set are focused on the ages 18 to 19 years.

Maturity – Adolescents typically experience changes in perception of body image, so it is important to assess the stability of each individual's self image before proceeding with plastic surgery. There are four attributes associated with body image that should be considered. These include physical reality of the appearance, perceptions of appearance, importance of appearance and the degree of satisfaction with appearance.

In addition, adolescents may not have the physical and/or emotional maturity to choose plastic surgery. They may have unrealistic expectations about the surgery itself or about the outcome. They also may not understand that additional surgery may be necessary because of complications or a change in personal desire. Finally, they may not have reached full physical development.

Informed Consent – It is important that the adolescent patient completely understand the procedure, possible complications and likelihood for additional procedures at some future date. As with all cosmetic procedures, appropriate informed consent will be required. The education process associated with an informed consent should help the patient and the parent/guardian understand the risks, benefits and potential complications associated with the procedure.

Region 1:
New England (CT, ME, MA, NH, RI, VT)
Middle Atlantic (NJ, NY, PA)

Region 2:
East North Central (IL, IN, MI, OH, WI)
West North Central (IA, KS, MN, MO, NE, ND, SD)

Region 3:
South Atlantic (DE, DC, FL, GA, MD, NC, SC, VA, WV)

Region 4:
East South Central (AL, KY, MS, TN)
West South Central (AR, LA, OK, TX)

Region 5:
Mountain (AZ, CO, ID, MT, NV, NM, UT, WY)
Pacific (AK, CA, HI, OR, WA)

2024 REGIONAL DISTRIBUTION COSMETIC SURGICAL PROCEDURES	TOTAL	% of PROCEDURES	TOTAL	% of PROCEDURES
COSMETIC SURGICAL PROCEDURES - BREAST	**Region 1**		**Region 2**	
Breast augmentation (implant placement for both primary and/or revisions)**	34,406	11%	46,226	15%
Breast implant removals (augmentation patients only)**	3,527	9%	4,703	11%
Breast lift (mastopexy)**	15,022	10%	21,930	14%
Breast reduction (aesthetic patients only)**	9,468	12%	12,046	16%
Breast reduction in males (gynecomastia surgery)**	3,942	15%	5,000	19%
COSMETIC SURGICAL PROCEDURES - BODY				
Abdominoplasty (tummy tuck)**	20,377	12%	27,496	16%
Buttock augmentation with fat grafting**	2,465	8%	1,319	4%
Buttock implants**	70	6%	9	1%
Buttock lift**	2,147	27%	420	5%
Labiaplasty**	955	9%	1,232	11%
Liposuction	30,753	9%	46,173	13%
Lower body lift**	1,098	10%	1,986	18%
Thigh lift**	1,219	12%	1,468	15%
Upper arm lift (brachioplasty)**	3,036	13%	4,255	18%
COSMETIC SURGICAL PROCEDURES - FACE				
Buccal fat pad removal**	334	7%	527	11%
Cheek implant (malar augmentation)**	244	3%	577	6%
Chin augmentation (mentoplasty)**	563	10%	1,822	33%
Ear surgery (otoplasty)**	459	10%	621	13%
Eyelid surgery (blepharoplasty)**	14,277	12%	16,177	13%
Facelift (rhytidectomy)**	9,854	12%	10,110	13%
Facial fat grafting**	4,115	12%	4,987	15%
Forehead lift**	1,419	10%	1,585	12%
Liposuction (submental/chin)	4,143	17%	1,914	8%
Neck lift**	1,681	7%	4,000	18%
Nose reshaping (rhinoplasty)**	8,333	17%	8,372	17%
TOTAL COSMETIC SURGICAL PROCEDURES	**173,907**	**11%**	**224,955**	**14%**
COSMETIC MINIMALLY INVASIVE PROCEDURES				
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	1,237,630	13%	1,302,670	13%
Lip augmentation (with injectable materials)	244,371	17%	238,016	16%
Noninvasive fat reduction (e.g., CoolSculpting®, Liposonix® , Emsculpt®, Vanquish®, Zerona®, Kybella®)	76,089	17%	49,234	11%
Non-surgical skin tightening (e.g., Pelleve®, Thermage®, Ulthera®)	31,270	7%	65,069	15%
Sclerotherapy	37,969	7%	168,898	33%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, micro-dermabrasion)	307,638	8%	649,091	18%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	345,591	11%	562,968	18%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Bolvella®, Restylane®)	885,005	17%	712,284	13%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	100,894	11%	174,240	19%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**3,266,457**	**13%**	**3,922,470**	**15%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

2024 REGIONAL DISTRIBUTION COSMETIC SURGICAL PROCEDURES	TOTAL	% of PROCEDURES	TOTAL	% of PROCEDURES	TOTAL	% of PROCEDURES
COSMETIC SURGICAL PROCEDURES - BREAST	**Region 3**		**Region 4**		**Region 5**	
Breast augmentation (implant placement for both primary and/or revisions)**	62,274	20%	51,214	17%	112,076	37%
Breast implant removals (augmentation patients only)**	11,602	28%	6,821	17%	14,618	35%
Breast lift (mastopexy)**	43,478	28%	30,568	20%	42,618	28%
Breast reduction (aesthetic patients only)**	20,384	27%	12,699	17%	22,137	29%
Breast reduction in males (gynecomastia surgery)**	6,354	24%	4,132	16%	7,002	26%
COSMETIC SURGICAL PROCEDURES - BODY						
Abdominoplasty (tummy tuck)**	45,911	27%	34,313	20%	42,967	25%
Buttock augmentation with fat grafting**	14,759	50%	4,625	16%	6,298	21%
Buttock implants**	198	16%	534	43%	434	35%
Buttock lift**	1,873	24%	2,534	32%	980	12%
Labiaplasty**	2,483	23%	1,923	18%	4,234	39%
Liposuction	122,724	35%	66,930	19%	83,148	24%
Lower body lift**	1,936	18%	2,930	27%	3,007	27%
Thigh lift**	2,625	26%	2,182	22%	2,420	24%
Upper arm lift (brachioplasty)**	6,635	28%	4,595	20%	5,006	21%
COSMETIC SURGICAL PROCEDURES - FACE						
Buccal fat pad removal**	849	17%	543	11%	2,650	54%
Cheek implant (malar augmentation)**	123	1%	1,428	16%	6,758	74%
Chin augmentation (mentoplasty)**	752	14%	599	11%	1,793	32%
Ear surgery (otoplasty)**	1,006	21%	765	16%	1,974	41%
Eyelid surgery (blepharoplasty)**	35,887	30%	18,739	16%	35,675	30%
Facelift (rhytidectomy)**	22,718	29%	13,455	17%	22,921	29%
Facial fat grafting**	6,835	20%	6,450	19%	11,873	35%
Forehead lift**	2,646	19%	2,074	15%	5,897	43%
Liposuction (submental/chin)	7,798	32%	4,999	21%	5,146	21%
Neck lift**	4,917	22%	5,138	23%	6,709	30%
Nose reshaping (rhinoplasty)**	11,105	23%	8,505	18%	12,108	25%
TOTAL COSMETIC SURGICAL PROCEDURES	**437,872**	**28%**	**288,695**	**18%**	**460,449**	**29%**
COSMETIC MINIMALLY INVASIVE PROCEDURES						
Neuromodulator injection (Botox®, Dysport®, Xeomin®, Jeuveau®, Daxxify®)	3,009,097	30%	2,025,025	20%	2,309,289	23%
Lip augmentation (with injectable materials)	413,526	29%	226,113	16%	327,539	23%
Noninvasive fat reduction (e.g., CoolSculpting®, Liposonix® , Emsculpt®, Vanquish®, Zerona®, Kybella®)	107,419	24%	58,186	13%	161,129	36%
Non-surgical skin tightening (e.g., Pelleve®, Thermage®, Ulthera®)	86,522	20%	60,866	14%	195,305	44%
Sclerotherapy	126,080	24%	110,813	21%	73,123	14%
Skin resurfacing (e.g., dermabrasion, chemical peel, ablative/non-ablative lasers, microdermabrasion)	785,655	21%	880,950	24%	1,079,971	29%
Skin treatment (combination lasers) (e.g., laser hair removal, IPL treatment, laser tattoo removal, laser treatment of leg veins)	540,818	17%	397,609	13%	1,265,070	41%
HA fillers (e.g., Juvederm Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero®, Bolvella®, Restylane®)	1,118,518	21%	838,497	16%	1,777,122	33%
Non-HA fillers (e.g., Radiesse®, Sculptra®, Bellafill®, Renuva®)	240,958	26%	83,082	9%	333,687	36%
TOTAL COSMETIC MINIMALLY INVASIVE PROCEDURES	**6,428,593**	**25%**	**4,681,141**	**18%**	**7,522,235**	**29%**

*** Counts of procedures performed by ASPS Member Surgeons only.*

Statement of Methodology

Since 1992, the American Society of Plastic Surgeons (ASPS) has been the source of cosmetic and reconstructive plastic surgery statistical trends in the United States, and this series represents more than three decades of procedural data.

ASPS is dedicated to bringing you the most accurate and reliable data in the specialty. For 2024, the Society used data from member surgeons and ASPS Endorsed Partner CosmetAssure. Combined, these sources give the data added breadth and depth to provide a more comprehensive report, strengthening credibility as a resource for doctors, patients, researchers and the media.

The Society offers the most comprehensive, reliable statistics on cosmetic and reconstructive plastic surgery procedures performed in the United States. The annual questionnaire was distributed to over 5,000 ABPS board-certified plastic surgeon members of ASPS. We received almost 1,000 responses which were included in the final sample.

All responses are aggregated and extrapolated to the entire population most likely to perform cosmetic and reconstructive plastic surgery procedures, resulting in the most accurate census available.

Statement of Validity

The results of the survey are based on a 95% confidence level with a +/- 4.62 percent margin of error.

Glossary

Abdominoplasty (Tummy Tuck): A surgical procedure to correct the apron of excess skin that hangs over the abdomen.

American Board of Medical Specialties: A nationally recognized, not-for-profit organization that sets professional standards for medical specialty practice and certification in partnership with its 24 certifying member boards.

American Board of Plastic Surgery: Certifying board for plastic surgeons in the United States. One of 24 specialty boards recognized by the American Board of Medical Specialties. Credential guarantees the surgeon graduated from an accredited medical school and completed at least five years of additional training as a resident surgeon. This includes a minimum of five years of residency training in all areas of surgery, including at least two years solely in plastic surgery. The surgeon then completes comprehensive written and oral exams.

Blepharoplasty (Eyelid Surgery): Surgery to improve the eyelids - upper lids, lower lids, or both.

Board-Certified Plastic Surgeon: A surgeon who chooses to obtain additional education in the specialty of plastic surgery. The surgeon has satisfactorily completed an approved residency training program and passed a rigorous specialty examination through the American Board of Plastic Surgery, which is recognized by the American Board of Medical Specialties. This certification is different from possessing a medical license, which is the minimum required by law to practice medicine and is not specialty specific.

Brachioplasty (Upper Arm Lift): A surgical procedure to reshape the underside of the upper arm from the underarm region to the elbow.

Breast Augmentation: Breast enlargement by surgery using implants or fat grafting. Medically known as augmentation mammaplasty.

Breast Implant Removal: To take out breast implants and possibly the breast capsule, which is scar tissue that forms after the placement of a breast implant. Also known as explant surgery.

Breast Lift (Mastopexy): A surgical procedure that raises the breasts by removing excess skin and tightens the surrounding tissue to reshape and support the new breast contour.

Breast Reconstruction: Plastic surgery techniques that attempt to restore a breast to near-normal shape, appearance and size following a mastectomy.

Breast Reduction: Surgically decreasing the size of the breast. Also known as reduction mammaplasty.

Breast Reduction in Males (Gynecomastia Surgery): Reduces the breast size in men by flattening and enhancing the chest contours.

Buccal Fat Pad Removal: A surgical procedure to extract the naturally occurring pad of fat in the cheek hollow area.

Buttock Augmentation with Fat Grafting: The transfer of fat from one area of the body using liposuction into the tissues of the buttocks. This technique is popularly referred to as Brazilian butt lift or BBL.

Buttock Implants: Silicone-filled devices that are surgically placed deep within the tissues of the buttock to enhance the shape and size of the posterior.

Buttock Lift: A surgical procedure to improve the shape and tone of the underlying tissue that supports skin and fat in the buttock area. Also known as a gluteal lift.

Burn Care: A reconstructive surgical procedure to repair skin or tissue damage usually caused by heat.

Cheek Implant (Malar Augmentation): A surgical procedure to add volume with implants or fat grafting (using the patient's own fat) that lifts the cheeks.

Chin Augmentation (Mentoplasty): A surgical procedure to reshape the chin either by enhancing it with an implant or reducing the bone.

Cleft Lip and Palate Repair: A reconstructive surgical procedure to close a gap in the upper lip and roof of the mouth usually caused by a birth defect when tissues do not completely join together.

Cosmetic Surgery: Procedures performed to enhance a person's overall aesthetic appearance by reshaping and adjusting normal anatomy to make it visually more appealing. It is not considered medically necessary and often not covered by medical insurance plans. Recovery can take considerable time before a patient can return to their day-to-day routine. Examples include facelifts, tummy tucks, rhinoplasty (nose reshaping) and breast augmentation.

Ear Surgery (Otoplasty): A surgical procedure to improve the shape, position or proportion of the ear.

Eyelid Surgery (Blepharoplasty): Surgery to improve the eyelids - upper lids, lower lids, or both.

Facelift (Rhytidectomy): A surgical procedure to reduce sagging of the mid-face, jowls and neck.

Facial Fat Grafting: A surgical procedure where fat is transferred from one area of the body to the face to add volume.

Glossary

Forehead Lift: A surgical procedure to correct a low-positioned or sagging brow. Smooths wrinkles that develop horizontally across the forehead and the vertical creases that develop between the eyebrows. Also known as a brow lift.

GLP-1 (Semaglutide): A medication used to treat obesity for long-term weight management. It is a peptide similar to the hormone glucagon-like peptide-1. It can be injected or taken orally. Brand names include Ozempic® and Wegovy®.

Gynecomastia Surgery: Breast reduction in males to flatten and enhance the chest contours.

Hand Surgery: A reconstructive surgical procedure to repair, improve or rehabilitate injuries or abnormalities that affect the strength, function or flexibility of the wrist or fingers. Treatments can improve carpal tunnel syndrome, arthritis or trigger finger.

Head and Neck Reconstruction: A surgical procedure to rebuild or reshape the face and neck using blood vessels, bone, tissue, muscle and skin from other parts of the body.

Hernia Repair: A reconstructive surgical procedure that fixes a bulging, usually of the stomach or intestines, through the wall of the cavity containing it. Medically known as a herniorrhaphy.

Hyaluronic Acid Fillers: Injections used to diminish facial lines and restore volume and fullness to the face. Hyaluronic acid is found naturally in the body. The dermal filler attracts water, which hydrates the skin and plumps it. This is a minimally invasive procedure. Examples include Juvederm®, Ultra®, Ultra Plus®, Voluma®, Volbella®, Vollure®, Restylane Lyft®, Restylane Silk®, Belotero® and Restylane®.

Labiaplasty: A surgical procedure to decrease the size of the labia minora (inner tissue of the female genitalia) so that is it flush with the labia majora (outer part of the female genitalia).

Laceration Repair: A reconstructive surgical procedure to fix a tear or cut in the skin, tissue or muscle.

Lip Augmentation: A minimally invasive cosmetic procedure where dermal filler, usually hyaluronic acid filler, is injected to plump lips, enhance the contours or diminish facial lines.

Liposuction: This procedure vacuums out fat from beneath the skin's surface to reduce fullness. Medically known as lipoplasty or suction lipectomy.

Lower Body Lift: The surgical removal of excess skin and fat from the abdomen, waist, hips, buttocks and thighs to improve the shape and tone of these areas.

Lower Extremity Reconstruction: A surgical procedure to restore form and function to an area from the hip to the toes.

Malar Augmentation (Cheek Augmentation): A surgical procedure to add volume with implants or fat grafting (using the patient's own fat) that lifts the cheeks.

Mastopexy (Breast Lift): A surgical procedure that raises the breasts by removing excess skin and tightens the surrounding tissue to reshape and support the new breast contour.

Maxillofacial: Relates to the mouth, jaw, face and neck. Surgical procedures focusing on this area can restore or improve essential functions such as speaking, chewing, swallowing and breathing. It can be both reconstructive and cosmetic. Procedures include facial fracture repairs, facial laceration repairs and orthognathic (jaw straightening) surgery.

Mentoplasty (Chin Augmentation): A surgical procedure to reshape the chin either by enhancing it with an implant or reducing the bone.

Microdermabrasion: A treatment that uses a minimally abrasive instrument to gently sand skin, removing the thicker, uneven outer layer. It helps to thicken collagen in the skin, which results in a younger-looking complexion. This is a minimally invasive procedure.

Minimally Invasive Procedures: An alternative to an invasive surgical operation that does not involve anesthesia and can be done on an outpatient basis. The recovery process post-procedure is typically not as intense, long or in-depth as with surgery. Examples include neuromodulator injections, hyaluronic fillers, skin resurfacing, laser treatments and more.

Neck Lift: A surgical procedure that improves visible signs of aging such as sagging jowls, muscle banding in the neck or excess fat in the jawline. Also known as a lower rhytidectomy.

Neuromodulator: An injectable that temporarily reduces or eliminates facial fine lines and wrinkles, made from a purified substance derived from bacteria. Injections block the nerve signals to the muscle in which it is injected, making the muscle unable to contract. This is a minimally invasive procedure. Examples include Botox® , Dysport® , Xeomin® , Jeuveau® and Daxxify® .

Non-Hyaluronic Acid Fillers: Injectable dermal filler that uses different active ingredients than hyaluronic acid. It is used to fill in facial lines to reduce wrinkles and is semi-permanent, lasting longer than hyaluronic acid fillers. This is a minimally invasive procedure. Examples include Radiesse®, Sculptra®, Bellafill® and Renuva®.

Glossary

Noninvasive Fat Reduction: Nonsurgical, minimally invasive treatment that uses lasers, heat, cooling or sound waves to destroy fat cells that will be removed from the body as metabolic products. Examples include CoolSculpting®, Lipsonix®, Emsculpt®, Vanquish®, Zerona® and Kybella®.

Noninvasive Skin Tightening: A minimally invasive procedure to firm sagging skin that uses targeted energy to heat deeper layers of skin, which stimulates collagen and elastin production and gradually improves skin tone and texture. Examples include Pelleve®, Thermage® and Ulthera®.

Nose Reshaping (Rhinoplasty): A surgical procedure that enhances facial harmony and proportions of the nose. It can also correct impaired breathing caused by structural defects in the nose. Commonly referred to as a nose job.

Otoplasty (Ear Surgery): A surgical procedure to improve the shape, position or proportion of the ear.

Pelvic Floor Reconstruction: A surgical procedure used to treat pelvic organ prolapse, when one or more of the organs including the uterus, bowel or bladder slip down from their normal position and bulge into the vagina.

Plastic Surgery: A surgical specialty that is not confined to a single organ system involving repairing, reconstructing or altering the human body either to restore form and function or improve its aesthetic. This includes both reconstruction and cosmetic procedures.

Reconstructive Procedures: Surgery or treatments performed to restore function and normal appearance or to correct deformities created by birth defects, trauma or medical conditions including cancer. It is considered medically necessary and is covered by most health insurance plans. Examples include breast reconstruction as well as cleft lip and cleft palate repair.

Rhinoplasty (Nose Reshaping): A surgical procedure that enhances facial harmony and proportions of the nose. It can also correct impaired breathing caused by structural defects in the nose. Commonly referred to as a nose job.

Rhytidectomy (Facelift): A surgical procedure to reduce sagging of the mid-face, jowls and neck.

Scar Revision: A reconstructive surgery that attempts to minimize markings from an injury so that is it less visible and blends more with the surrounding skin tone and texture.

Sclerotherapy: A minimally invasive treatment to reduce spider veins. The most common treatment involves injecting a solution into each affected vein, causing the vein to collapse and fade. Laser treatments are also available.

Skin Resurfacing: A minimally invasive procedure to remove the outer layer of skin called the epidermis while simultaneously heating the underlying skin, called the dermis. This action works to stimulate the growth of new collagen allowing the new skin that forms to be smoother and firmer. Treatments include dermabrasion, chemical peels, ablative and non-ablative lasers as well as microdermabrasion.

Skin Treatment: A minimally invasive procedure that improves the appearance of the skin using lasers. Treatments include combination lasers, laser hair removal, intense pulsed light (IPL), laser tattoo removal and laser treatment of leg veins.

Submental Liposuction: A minimally invasive surgical procedure to remove excess fat from under the chin and neck region. It can reduce the appearance of a double chin and contour the neck and jawline. Commonly referred to as chin liposuction or chin lipo.

Thigh Lift: A surgical procedure to reshape the thighs by reducing excess skin and fat, resulting in smoother skin and better-proportioned contours of the lower body.

Treatment of Dog Bites: A reconstructive surgery that repairs wounds to the skin, bones, tendons, nerves, vessels, muscles and joints sustained when a body part is seized by the teeth of a dog.

Tummy Tuck (Abdominoplasty): A surgical procedure to correct the apron of excess skin that hangs over the abdomen.

Tumor Removal: A reconstructive surgery to eliminate an abnormal growth or mass, which may be cancerous or benign, while leaving the surrounding healthy tissue intact. This includes skin cancer excisions.

Upper Arm Lift (Brachioplasty): A surgical procedure to reshape the underside of the upper arm from the underarm region to the elbow.

Further Information

Exclusive Full-Color Graphics and Comprehensive Statistical Graphs at Your Fingertips

Full-color graphics and statistical graphs for this release are available by contacting the ASPS Public Relations Department. We invite you to contact us via media@plasticsurgery.org or at (847) 228-3333.

ASPS Spokespersons Network

Looking for expert insights on plastic surgery? The ASPS Spokespersons Network boasts over 100 plastic surgeons from the U.S. and Canada. They're not just experts in procedural details but are also well-versed in patient-physician dynamics, emerging trends and even societal impacts like healthcare reform. If you're a journalist seeking an informed perspective, contact the ASPS Public Relations Department to schedule an interview.

PlasticSurgery.org

The ASPS online newsroom is the most comprehensive site for journalistic research on cosmetic and reconstructive plastic surgery on the Internet. Discover the most comprehensive journalistic resources on cosmetic and reconstructive plastic surgery. At PlasticSurgery.org, you'll find:

- Recent news releases
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Attorneys for Plaintiff EmblemHealth, Inc.

UNITED STATES DISTRICT COURT
DISTRICT OF NEW JERSEY

EMBLEMHEALTH, INC., Plaintiff, -against- NORMAN M. ROWE, M.D., NORMAN M. ROWE, M.D. PLLC, NORMAN M. ROWE MD OF NEW JERSEY LLC, ROWE PLASTIC SURGERY OF NEW JERSEY LLC, and EAST COAST PLASTIC SURGERY PLLC PA, Defendants.	Case No. 26-cv-3311 (SDW) (MAH)

DECLARATION OF JUAN OLIVO-CASTRO IN OPPOSITION TO DEFENDANTS' MOTION TO DISMISS

I, JUAN OLIVO-CASTRO, of full age, hereby state as follows:

1. I am an attorney duly admitted to practice law in the State of New Jersey and in good standing to practice before this Court. I am an Associate of the law firm

Tarter Krinsky & Drogin LLP, counsel for plaintiff EmblemHealth, Inc. ("Emblem" or "Plaintiff") in the above-captioned action. As such, I am fully familiar with the matters set forth herein.

2. I submit this Declaration in opposition to the motion ("Motion") filed by Defendants to dismiss the Complaint and stay all discovery.

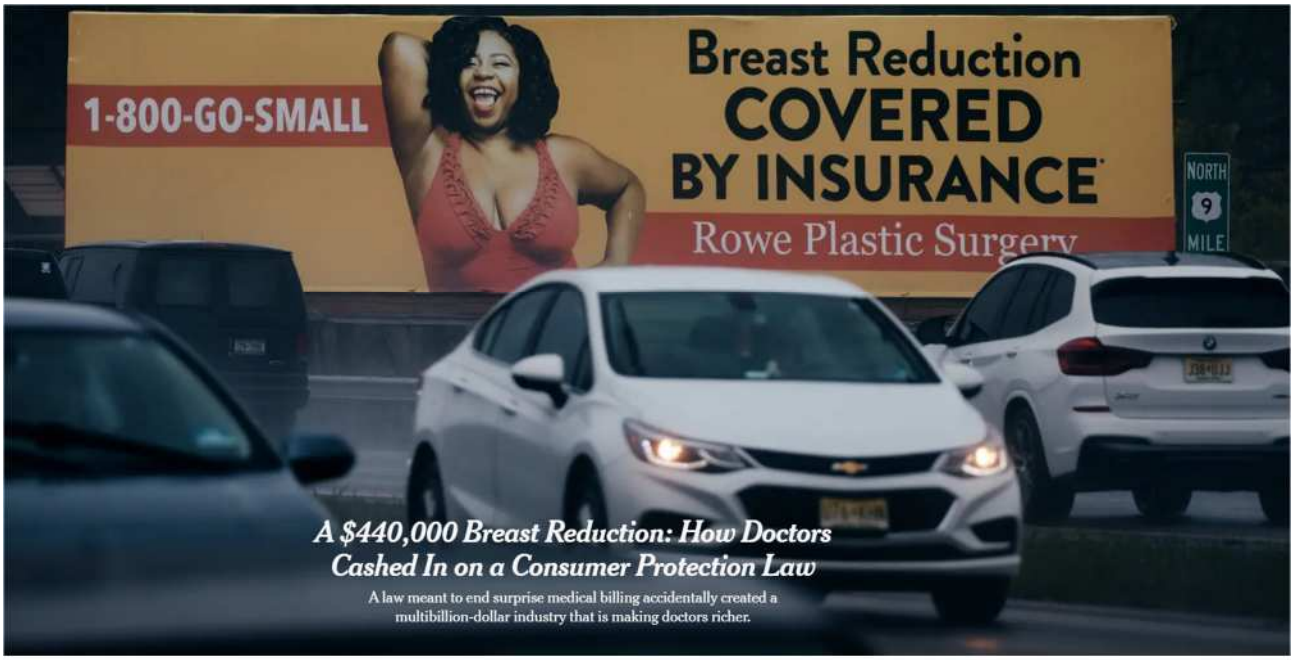
3. Annexed hereto as **Exhibit "A"** is a true and correct copy of an article, authored by Sarah Kliff and Margot Sanger-Katz, which appeared in the *New York Times* on April 22, 2026.

I declare under the laws of the United States of America and penalty of perjury that the foregoing is true and correct.

Dated: New York, New York
June 22, 2026

/s/ *Juan Olivo-Castro*

EXHIBIT A



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By Sarah Kliff and Margot Sanger-Katz

The reporters analyzed data on more than three million arbitration disputes and reviewed dozens of lawsuits.

April 22, 2026

Leer en español

Dr. Norman Rowe, a plastic surgeon with offices in New York and Florida, advertises on his website that breast reduction surgery usually costs between $15,000 and $25,000.

But these days, his practice sometimes earns $440,000 for the procedure.

Dr. Rowe has taken full advantage of a new arbitration system, part of a major consumer protection law Congress passed in 2020 with bipartisan majorities. The No Surprises Act was designed to eliminate surprise medical bills, for patients who showed up in the emergency room and were treated by a doctor who didn't take their insurance.

It bars those out-of-network doctors from billing patients directly. Instead, they can plead their case to a government-approved arbitrator. If they win, the patient's insurer has to pay their desired amount.

By all accounts, the law is successfully protecting patients against bills from doctors they never chose. But it has also generated an expensive unanticipated consequence: Doctors have flooded the arbitration system with millions of claims. Most are winning, often collecting fees hundreds of times higher than what they could negotiate with insurers directly or what they could have earned from patients before the law passed.

"I'm still glad we passed the bill, because we got consumers out of it, but we need to rein in this arbitration process," said Representative Frank Pallone Jr., Democrat of New Jersey, who helped negotiate the law.

Some health plans said they have increased premiums this year to cover the extra costs. The United Service Workers health plan, which covers 20,000 trades workers in the New York area, said it boosted premiums by an extra 1.75 percentage points to offset arbitration awards and fees. The system has also enriched a new class of specialized businesses, which assist doctors in navigating the bureaucratic process.

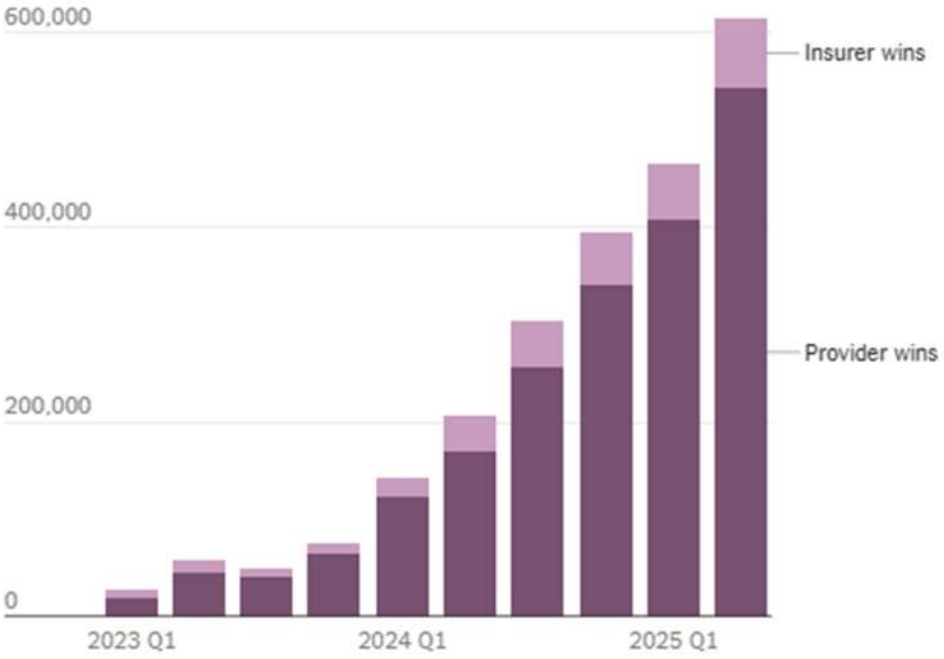
"This is a recipe for driving up health care costs," said Karen Ignagni, the executive chair of EmblemHealth, which sued Dr. Rowe in March, arguing his use of arbitration amounted to fraud. "There are no checks. There are no balances. There's no oversight."

When the law passed, government officials estimated that about 17,000 cases would go to arbitration a year. Instead, doctors brought 1.2 million such cases in the first half of last year, and won around 88 percent of them.

The arbitrators are doing well too. The fees they earn for deciding cases, which range from $425 to $1,150 per case, have added up.

The Number of Disputes in Arbitration Has Exploded

Cases per quarter



A small share of cases, less than 1 percent, are categorized as "split decisions." They are not pictured. Source: Centers for Medicare and Medicaid Services By The New York Times

In arbitration, doctors and insurers each propose a price for the care, along with arguments for why it is appropriate. An arbitrator must pick one of the two numbers, and there is no opportunity to appeal the decision.

Arbitrators have repeatedly approved doctors' submissions of extremely high prices for common medical procedures, according to court filings and a New York Times analysis of a large public data set with basic information on each dispute.

A neurosurgery practice outside of Philadelphia went to arbitration after the health plan Highmark offered its standard payment of $2,660 for a diagnostic procedure to measure blood flow to the brain. An arbitrator awarded it $333,000 instead. A New Jersey anesthesiologist was awarded $14,560 in 2025 for an X-ray-guided steroid injection.

Many claims that shouldn't be eligible for arbitration, such as those for patients covered through the government programs Medicare

and Medicaid, move through the system anyway. The claim from the New Jersey anesthesiologist involved a patient on a UnitedHealthcare Medicare Advantage plan, according to a lawsuit that UnitedHealth has filed protesting the arbitration decision.

The doctor's billing company recognized the submission was a mistake, and tried to withdraw it before the decision. But his lawyer, Eric Katz, said that the arbitrator clearly thought the award was appropriate.

"No one put a gun to anyone's head," he said. "If the plans have issues with the way this is being handled, take it up with Congress."

Medical specialties like spinal and plastic surgery, for which surprise bills were rare before the law, now frequently have cases in arbitration, according to the public data. Some practices are using the law to obtain high payments for routine medical care, including gynecologists who have won fees 600 times higher than usual rates for placing intrauterine contraceptive devices, or I.U.D.s.

A Rowe Plastic Surgery location in Red Bank, N.J. Andres Kudacki for The New York Times

The money does not always end up with the doctors but instead can go to the owners of their practices. The Times interviewed two physicians who show up repeatedly in public data files. Both said they were salaried workers and uninvolved in the claims filed under their names.

The government has hired 15 firms, some boutique vendors and others large contractors, to arbitrate billing disputes. Doctors and insurers can select a firm if they agree, or be randomly assigned one if they do not.

Health policy experts have been surprised to see such lopsided results that favor doctors. Some argue that because the arbitrators are paid per case, they may have an incentive to render decisions that keep doctors coming back.

Arbitrators may also, like the broader public, prefer doctors to insurers, said Matthew Fiedler, a senior fellow at the Brookings Institution who has studied the law. "Arbitrators are people, and the typical person likes physicians."

David Farber, a lawyer for the newly formed Coalition of Independent Dispute Resolution Entities, a trade group representing some of the arbitration firms, disputed the notion that arbitrators acted improperly.

"We're getting the job done," he said. "And the job is getting done consistent with how Congress set the process up to work."

Doctors contend that they only pursue arbitration when insurers offer unreasonably low payments.

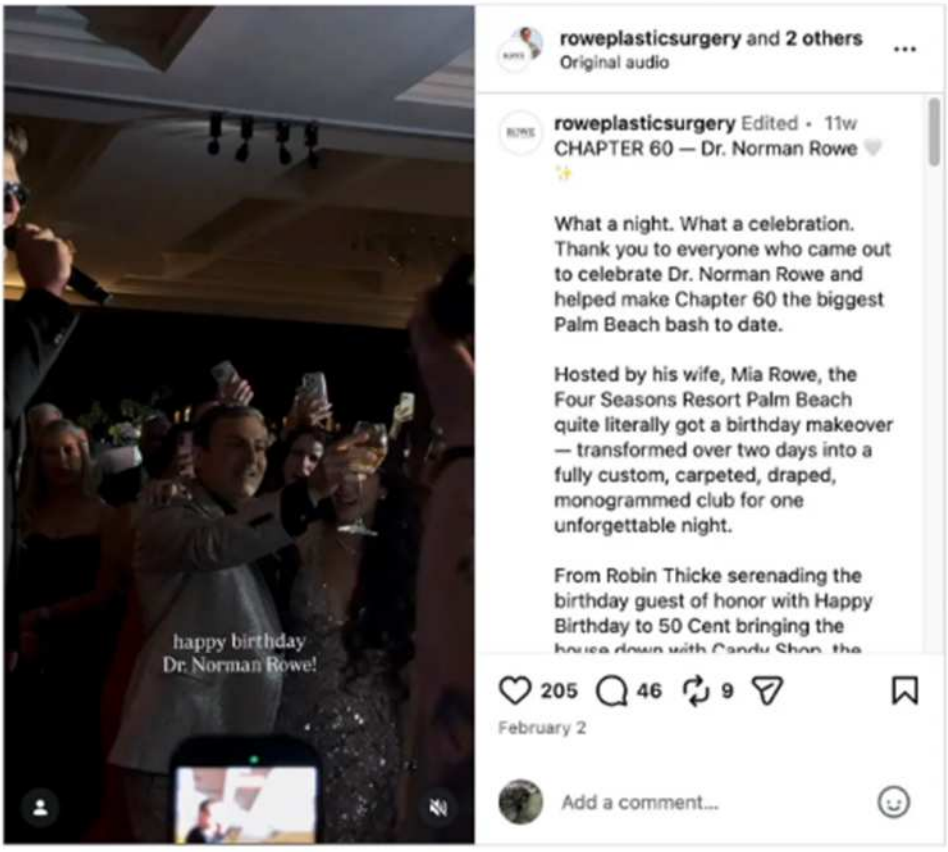
"We have very strong preference to be in network at sustainable rates," said Dr. Richard Heller, a senior vice president at Radiology Partners, which employs over 4,000 radiologists. The company now has 150 staff members working to bring arbitration claims.

‘Eyebrow-raisingly high’

Dr. Rowe has practiced for decades on New York City’s Park Avenue and in New Jersey. Last winter, he opened an office in Palm Beach, a few miles from President Trump’s Mar-a-Lago resort. Just before the inauguration, he told The New York Post the office had been overrun with clients who wanted to look good when they “have face time with the leader of the free world.”

Dr. Rowe did not respond to multiple requests for comment from The Times.

On social media, he flaunts a lavish lifestyle. An Instagram post in February detailing his 60th birthday party featured a performance from the rapper 50 Cent and a custom-cake recreation of his 1950s vintage Porsche.



A video posted on Dr. Rowe’s Instagram showed Dr. Rowe celebrating his 60th birthday with appearances by celebrities 50 Cent and Robin Thicke.

Health insurers do not cover many of the elective procedures that Dr. Rowe provides, such as penis enlargement. That service became a big enough part of his practice that he has trademarked the nicknames "Dr. Penis" and "Doctor Penis."

Breast reductions, however, are different. They are often treated as medically necessary because they can reduce back and neck pain.

Before the No Surprises Act, Dr. Rowe's practice was out of network with EmblemHealth, but he accepted fees $30,000 or lower for hundreds of breast reduction surgeries, the lawsuit claims.

In 2024, the lawsuit says, he started routinely performing surgeries on EmblemHealth patients in hospitals that accepted the insurer's in-network payments, though he still did not.

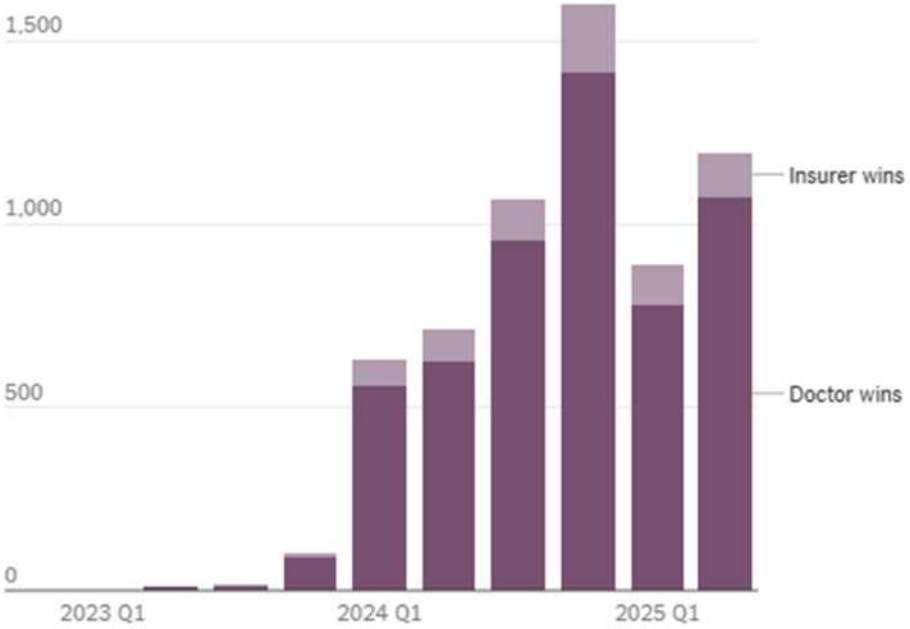
Under the No Surprises Act, doctors in such situations can provide patients with a waiver that warns of additional costs. If patients sign that form, the doctor has permission to bill them directly.

Dr. Rowe does not hand out that waiver. That allows him to take his payment disputes to arbitration.

He and his practice have filed more than 6,000 arbitration claims, according to an analysis of public filings from the Georgetown University Center on Health Insurance Reforms. He has won more than 85 percent of his cases.

Dr. Rowe's Winning Track Record

Cases per quarter



The totals combine numerous variations on the names of Dr. Rowe's practices, Rowe Plastic Surgery and East Coast Plastic Surgery, in the public filing system. Source: Georgetown Center on Health Insurance Reforms. By The New York Times

The lawsuit offers details about five of those cases, all for elective breast reduction surgeries.

In the first case, in November 2024, Dr. Rowe won a payment of $112,500 that covered his work and the work of an assistant surgeon. In the fifth one, in late December 2025, his practice brought and won separate claims for each surgeon, totaling $440,000. Altogether, the practice won more than $1.4 million from those five surgeries alone.

EmblemHealth's strategy also changed over time. According to the suit, the company started with a low counteroffer, around $6,000. Over time, it tried offering fees as high as $124,000, but continued to lose. The plan's lawyers also started including language in their briefs stating that Dr. Rowe "has a pattern of exploiting" the process.

Dr. Rowe's briefs to the arbitrator are not public, so it is unclear exactly what arguments he made to justify the much higher rates he was claiming in arbitration. The law directs arbitrators to consider several factors, including the usual price insurers pay, the doctor's experience and the patient's complexity.

Elevance Health, another insurer, said that breast reduction surgeries are now its most expensive category of arbitration claims. Ariel Bayewitz, the company's vice president of health economics, said one Connecticut plastic surgery practice has escalated its earnings from the procedure, beginning at $70,000 in 2024 and hitting $440,000 late last year.

Michael Gottlieb, the lawyer who handles Dr. Rowe's arbitration filings, declined to speak about continuing litigation but did broadly defend his clients' seeking much higher amounts than insurers typically pay. He described the arbitrators as having "reverse sticker shock" at how low the health plan payments were.

"When they got wind of three-digit payments for massive, complex surgeries and they know they pay their plumber more to fix a toilet, they just gravitate toward the providers' offers even if they do seem eyebrow-raisingly high," he said.

Arbitration decisions are supposed to be binding, but Mr. Gottlieb said that health plans often refuse to send payment. He has sued multiple insurers over the issue.

In March, one doctor he represents received a letter from the Motion Picture Industry Health Plan, which provides coverage to many film workers. The letter, which The Times reviewed, stated that the plan would not pay the amount an arbitrator selected because it "does not constitute appropriate use of plan assets."

Silence in Congress

Surprise billing was an urgent topic in Congress, but these days in Washington, the law's unexpected results are rarely discussed. Eric Lee for The New York Times

For years before the No Surprises Act passed, surprise billing was an urgent topic in Congress. Lawmakers from both parties denounced the high bills that ambushed patients.

But these days in Washington, the law's unexpected results are rarely discussed. Instead, many legislators who worked on the law emphasize the success of consumer protections.

"My focus is on ensuring everyone can get the care they need without worrying about the cost," said Patty Murray, Democrat of Washington, who helped craft the bill.

Senator Bill Cassidy, Republican of Louisiana and a physician, who helped write the law, said the large awards were a sign that insurers were not making reasonable offers.

Senator Bill Cassidy, Republican of Louisiana and a physician, who helped write the law, said the large awards were a sign that insurers were not making reasonable offers.

"If they're winning, it's because the insurance companies are not coming back with a reasonable thing," he said.

In late 2023, the Biden administration proposed changes to the arbitration system, including more scrutiny of ineligible claims. The Trump administration has not yet put into place those reforms.

Only one bill has been introduced in Congress to change arbitration, and it would increase penalties on insurers that fail to pay doctors quickly after cases are concluded.

Seeing little movement in Washington, health plans have turned to the courts. They have filed at least 20 lawsuits against doctors and the companies they use to submit claims.

But this month judges in California and Florida dismissed two such cases, finding that Congress did not intend for judges to review the arbitration awards.

If an insurer believes doctors are acting improperly, the Florida judge wrote, it should "raise the issue" in arbitration.

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