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

ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC., Plaintiff, vs. EDMUND G. BROWN, JR., in his official capacity as Governor of the State of California, and Shelley Rouillard, in her official capacity as as the Director of the California Department Managed Health Care, Defendants.	) 2:16-cv-02441-MCE-EFB)) **PLAINTIFF'S**) **MEMORANDUM OF**) **POINTS AND**) **AUTHORITIES IN**) **OPPOSITION TO THE**) **MOTION FOR**) **JUDGMENT ON THE**) **PLEADINGS**) Date: Sept. 7, 2017) Time: 2:00 p.m.) Ctrm: 7) Judge: Hon. Morrison C. England, Jr.) Trial date:) Case filed: Oct. 13, 2016

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Plaintiff Association of American Physicians & Surgeons, Inc. ("AAPS") hereby files this Memorandum of Points and Authorities in Opposition to the Motion for Judgment on the Pleadings. [D.E. 13] Plaintiff AAPS has no objection to the Request for Judicial Notice in Support of Motion for Judgment on the Pleadings by Edmund G. Brown, Jr., and Shelley Rouillard ("Defendants"). [D.E. 13-2]

Introduction

"By any measure, handing off regulatory power to a private entity is 'legislative delegation in its most obnoxious form.'" *Dept. of Transp. v. Assoc. of American Railroads*, 135 S. Ct. 1225, 1238 (2015) (Alito, J., concurring) (quoting *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936)). Allowing health care plan providers to regulate reimbursement rates with the authority of government is unconstitutional.

Yet a new California law authorizes private entities – health care service plan providers – to impose wage and price controls on private physicians who have no relationship with the companies. The law is akin to authorizing the New England Patriots to set the compensation for San Francisco 49ers football players, or authorizing Exxon to set the price of gasoline at which its competitors must sell. Economically, "out-of-network" physicians are in competition with the plans' "in-network" physicians, and insurers should not be authorized to set rates for their competitors. Such a law is arbitrary and capricious, and in violation of the due process and takings clauses. The law is bad policy in addition to being unconstitutional. If left unchecked, the law will result in the rationing of care in underserved areas, and will discourage physicians from practicing in California altogether, while boosting the already prodigious profits of insurance companies. From a legal perspective, this extraordinary delegation of rate-setting authority to private plan providers as embodied in AB 72 is unconstitutional for multiple reasons. This law should be enjoined, and invalidated in whole or in part.

This new law that is the subject of this litigation is California Assembly Bill 72 ("AB 72" or the "Act"), signed into law on September 23, 2016, and effective July 1, 2017. AB 72 authorizes ***private*** plan providers to set the rates of reimbursement for

physicians not under any contract with them. When government sets rates, as in the context of utilities, there is political accountability for the officials, there is due process to challenge the rates, and there are safeguards against the taking of private property and against any violations of equal protection that may result. But those essential protections are utterly missing – and the corresponding constitutional provisions are thereby violated – when a legislature delegates rate-setting authority to private entities. Yet that is what AB 72 does, and it should be invalidated.

The purported purpose of AB 72 is to eliminate "surprise medical bills," but the statute obviously benefits providers of health care service plans far beyond what would be justified by that goal. A requirement of transparency, or simply of informed billing consent, would have attained the purported goal without delegating rate-setting authority to private companies. Indeed, the stated goal is not even advanced significantly by AB 72, because it does not even apply to emergency services or to uninsured patients. Instead, AB 72 benefits private health care plan providers by authorizing them to set fees for out-of-network physicians, giving plan providers leverage to drive them out of business.

Statement of Facts

Defendant California Governor Edmund G. Brown, Jr., signed AB 72 into law on September 23, 2016, and unless enjoined it will violate multiple constitutional rights of physicians and patients. (Compl. ¶ 1) In an unprecedented manner, AB 72 authorizes insurance companies to limit what physicians who are outside of their networks ("out-of-network" or "noncontracting") may charge. (*Id.* ¶ 2) This is akin to a company dictating how much a competitor – with which it has no contractual relationship – may receive in revenue. (*Id.*) AB 72 violates the Due Process Clause of the U.S. Constitution by delegating rate-setting authority to private companies, with respect to physicians who are not under any contract with the health care service plan providers, and by requiring arbitration for out-of-network physicians on their reimbursements, thereby denying them

their due process rights in court on their claims.[1] (*Id.* ¶ 3) AB 72 violates the Takings Clause of the U.S. Constitution because the Act empowers private insurance companies to deprive out-of-network physicians of the market value for their services, and arbitrarily denies them just compensation for their labor. (*Id.* ¶ 4) AB 72 violates the Equal Protection Clause of the U.S. Constitution by having a disparate impact on minority patients for whom the availability of medical care will sharply decline as out-of-network physicians are coerced by the Act to withdraw services from predominantly minority communities. (*Id.* ¶ 5)

These violations of constitutional rights by AB 72 cause harm to AAPS members who practice in California, and to their patients. (*Id.* ¶ 6) Plaintiff AAPS, on behalf of its members in California and their patients, seeks declaratory and injunctive relief. (*Id.* ¶ 7)

Plaintiff AAPS is a not-for-profit membership organization incorporated under the laws of Indiana and headquartered in Tucson, Arizona. (*Id.* ¶ 8) Founded in 1943, AAPS has members in virtually every specialty. (*Id.*) Many AAPS members are out-of-network with insurance companies, and many contribute charity care to patients in underserved and minority communities. (*Id.*) These members of AAPS in California are harmed by the violations of the U.S. Constitution by AB 72. (*Id.*) The protection of AAPS members from unconstitutional action is central to AAPS's mission on behalf of its members. (*Id.*)

Defendant Edmund G. Brown, Jr., in his official capacity as Governor of California, is the chief executive having the ultimate responsibility for enforcing AB 72. (*Id.* ¶ 9) Defendant Shelley Rouillard, in her official capacity as the Director of the California Department of Managed Health Care (the "Department"), is the executive authorized to implement AB 72. (*Id.* ¶ 10)

AAPS members, including California ophthalmologist Michael Couris, M.D.,

[1] Defendants object to the assertion of claims under the California Constitution, and for simplification those are left out and not asserted here. They are unnecessary in light of the claims based on similar clauses in the U.S. Constitution.

suffer imminent threatened injury in the form of denial of their rights under the Due Process, Takings, and Equal Protection Clauses, including financial harm, as a result of the enactment and upcoming enforcement of the Act. (*Id.* ¶ 14) In addition, with respect to the Equal Protection claims below, the patients of AAPS members suffer imminent threatened injury in the form of reduced availability for medical care to them. (*Id.*) The requested declaratory and injunctive relief will prevent these injuries, and does not require the participation of individual AAPS members. (*Id.* ¶ 15) The protection of its members from these constitutional violations is central to AAPS's purpose. (*Id.*)

Out-of-network physicians, who are called "noncontracting" physicians by AB 72, do not have the benefits or obligations of being contractually bound with insurance companies. (*Id.* ¶ 16) There are both advantages and disadvantages to patients and physicians resulting from an out-of-network status. (*Id.*) Some physicians are out-of-network not by choice, but because insurance companies increased their profits by excluding them for reasons other than quality of care. (*Id.* ¶ 17) Out-of-network physicians often lack the referral volume of physicians who are within the networks of insurance companies, and as a result out-of-network physicians tend to provide more charity care than in-network physicians do. (*Id.* ¶ 18) To remain in business, out-of-network physicians may charge more for certain services than the in-network insurance reimbursement rates. (*Id.*)

Insured patients, in many cases, obtain policies that require their insurance company to pay the charges by out-of-network physicians, or at least a substantial percentage of those charges. (*Id.* ¶ 19) The only meaningful leverage that a physician or hospital has in negotiating a contract with an insurance company is the option of the physician or hospital to go out-of-network and not accept the insurance company rates. (*Id.* ¶ 20) AB 72 denies the right of a physician to go out-of-network with an insurance company and charge out-of-network rates. (*Id.* ¶ 21) Signed into law by the Defendant Governor of California on September 23, 2016, AB 72 adds several new sections to the Health and Safety Code and the Insurance Code to limit the rights of reimbursement for

out-of-network physicians. (*Id.*) Specifically, the Act requires the following for out-of-network physicians, effective July 1, 2017: "the plan shall reimburse the greater of the average contracted rate or 125 percent of the amount Medicare reimburses." AB 72 § 2 (adding Section 1371.31 to the Health and Safety Code). (Compl. ¶ 22) AB 72 thereby prohibits an out-of-network physician from recovering fully on his claims for services lawfully rendered. (Compl. ¶¶ 23-24)

In addition, AB 72 requires the Department, by September 1, 2017, to "establish an independent dispute resolution process for the purpose of processing and resolving a claim dispute between a health care service plan and a noncontracting individual health professional for services" rendered. AB 72 § 1 (adding Section 1371.30 to the Health and Safety Code). Out-of-network physicians are thereby required to participate in this alternative dispute resolution on their claims, rather than pursue their remedies in court. (Compl. ¶ 25) AB 72 generally exempts medical services rendered on an emergency basis, but does not expressly exempt services rendered after transfer of a patient from an emergency room to an intensive-care unit (ICU). (*Id.* ¶ 26)

The price-setting by insurance companies under the Act with respect to out-of-network physicians imposes *confiscatory* rates in violation of the Due Process Clause.[2] (*Id.* ¶ 29) By requiring out-of-network physicians, including members of AAPS, to participate in arbitration rather than pursue their claims in court, AB 72 further violates this Due Process Clause. (*Id.* ¶ 30) AB 72 improperly shifts the burden onto physicians to challenge the price controls, and the Act denies them their due process rights to do so. (*Id.* ¶ 31) Plaintiff seeks declaratory and injunctive relief. (*Id.* ¶¶ 32-33, 40-41, 49-50)

The rate mechanism imposed by AB 72 deprives physicians of their property rights for their labor, without just compensation, which violates the Takings Clause. (*Id.*

[2] "Confiscatory", as used in numerous decisions and in this memorandum, refers to rates that are inadequate to fully compensate for the services provided. *See, e.g.*, *Guar. Nat'l Ins. Co. v. Gates*, 916 F.2d 508, 514 (9th Cir. 1990) (finding a constitutionally defective failure to "contain any provisions for relief from potentially confiscatory rates").

¶ 37) In addition, AB 72 violates this Takings Clause by transferring property from one private group (physicians) to other private entities, namely insurance companies, in the form of the latter's underpayment for services. (*Id.* ¶ 38)

Many out-of-network physicians, including members of Plaintiff AAPS, depend on their ability to bill market rates for their services to insured patients in order to be able to offer charity or undercompensated care to underserved minority patients. (*Id.* ¶ 44) Underserved minority patients depend on the continued availability of medical care from these out-of-network physicians, including members of Plaintiff AAPS. (*Id.* ¶ 45) The Act will force out-of-network physicians, including members of AAPS, out of business or into insurance networks that render it infeasible to provide substantial amounts of care to underserved, uninsured, predominantly minority patients. (*Id.* ¶ 46) These patients face imminent harm, in the form of lost access to out-of-network physicians and decreased availability of medical care, if AB 72 goes into effect. (*Id.* ¶ 47) The Act will have a disparate impact on these underserved, minority patients. (*Id.* ¶ 48)

Finally, only a small percentage of overall health care costs are attributable to physician fees. For example, in the roughly $600 billion Medicare program "roughly one-fourth was for hospital inpatient services, ***12% for physician services***, and 11% for the Part D drug benefit. Another one-fourth of benefit spending was for Medicare Advantage private health plans covering all Part A and Part B benefits …."[3]

Standard of Review

Plaintiff adopts Defendants' Standard of Review. (Defs Mem. 6-7)

Argument

AB 72 delegates to health care service plan providers the authority to set prices for market participants who have no relationship with the insurers, in violation of

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[3] http://www.kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/ (viewed Aug. 20, 2017, emphasis added).

multiple constitutional safeguards. (Compl. ¶¶ 7, 33, 41, 50) Plaintiff AAPS has stated valid causes of action, and it would be premature for Defendants' motion to be granted.

I. The Eleventh Amendment Does Not Bar Plaintiff's Claims Against the Governor.

Defendants concede that "[u]nder an exception to the Eleventh Amendment, a state official can sometimes be subject to a lawsuit in federal court challenging the official's oversight of a state law." (Defs Mem. 8, citing *Ex Parte Young*, 209 U.S. 123, 155-156 (1908)). That is what Plaintiff AAPS alleges here: that California Governor Jerry Brown has "oversight of a state law" that is unconstitutional, namely AB 72.

But Defendants go on to argue, citing a 25-year-old Ninth Circuit case, that "'there must be a connection between the official sued and enforcement of the allegedly unconstitutional statute, and there must be a threat of enforcement.'" (Defs Mem. 8, citing *Long v. Van de Kamp*, 961 F.2d 151, 152 (9th Cir. 1992)). There is. If Governor Brown does not like how his Executive Branch is implementing AB 72, then he can fire and replace the officials in charge of the implementation. This is fairly inferred from the allegation that Governor Brown is the "chief executive of California." (Compl. ¶ 9)

AB 72 became effective beginning July 1, 2017. The threat of enforcement is now, as AB 72 is currently the law of the land in California. Governor Brown could stay implementation or enforcement, but he has not done so. Physicians are justified in fearing enforcement of AB 72 under the authority of Governor Brown, and thus he should remain a defendant under the *Ex Parte Young* exception.

Plaintiff's Complaint is well within the delineation of the *Ex Parte Young* exception as explained by the Ninth Circuit:

> [O]ur traditional conception of the *Young* exception … has always distinguished between a suit against a State *qua* State and a suit against a state official to enjoin the enforcement of a state act that violates federal law: the *Young* doctrine has always permitted the latter to avoid the sovereign immunity bar.

Agua Caliente Band of Cahuilla Indians v. Hardin, 223 F.3d 1041, 1048 (9th Cir. 2000).

II. Plaintiff Has Standing to Bring This Constitutional Action.

Associational standing is alive and well here within the Ninth Circuit, as it is elsewhere. *See, e.g.*, *WildEarth Guardians v. United States Dep't of Agric.*, 795 F.3d 1148, 1154 (9th Cir. 2015) (reversing the district court's dismissal for lack of standing, and instead holding that standing exists for an environmental group to assert a claim based on allegations about predator damage management, where there was an alleged "interest in recreational and aesthetic enjoyment of predators in the Nevada wilderness").

Despite this, Defendants argue that Plaintiff somehow lacks "associational standing on behalf of its California physician-members" and lacks "third-party standing on behalf of its out-of-network members' unnamed patients, but only with respect to its equal protection claim." (Defs Mem. 9, citing Comp. ¶¶ 6, 8, 14) But Plaintiff AAPS has adequately alleged such standing, as explained below.

III. Plaintiff Has Standing to Bring This Action on Behalf of Its Physician Members.

Defendants correctly state the standard for associational standing, as set forth by the U.S. Supreme Court. (Defs Mem. 9, citing *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167, 181 (2000)). Defendants merely assert a one-paragraph objection with respect to the first prong of the standing requirement. (Defs Mem. 9-10) Specifically, Defendants argue that "missing from the complaint are allegations that the physician-members, who are out-of-network providers, (1) will not be reasonably reimbursed for their services (either through the Act's reimbursement methodology or the dispute resolution process), or (2) will be forced to abandon their practices and/or become in-network providers." (*Id.* 10) Defendants add that "[a]ny harm on the physician-members is based on what *may* happen in the future if at some point in time an out-of-network physician is ultimately denied reasonable reimbursement under this very narrow application of the Act." (*Id.*) Defendants then rely entirely on *Schmier v. U.S. Court of Appeals for Ninth Circuit,* 279 F.3d 817, 821 (9th Cir. 2002), distinguished below.

But Defendants' motion is for judgment on the pleadings, and the Complaint expressly satisfies the very test that Defendants argue. Plaintiff's Complaint does allege that that members of Plaintiff, "including California ophthalmologist Michael Couris, M.D.," will "suffer imminent threatened injury in the form of denial of their rights under the Due Process, Takings, and Equal Protection Clauses, including financial harm, as a result of the enactment and upcoming enforcement of the Act." (Compl. ¶ 14) The Complaint then details the harm, including a lack of reasonable reimbursement:

> This ban in the Act on collecting from enrollees has the effect of ***preventing out-of-network physicians from recovering their fees*** from the insurance carriers that cover the enrollees for services rendered. (Compl. ¶ 24, emphasis added)
>
> The price-setting by insurance companies under the Act with respect to out-of-network physicians ***imposes confiscatory rates*** in violation of this Due Process Clause. (*Id.* ¶ 29, emphasis added)
>
> The rate mechanism imposed by the Act ***constitutes confiscatory wage controls on physicians, thereby depriving them of their property rights for their labor, without just compensation,*** which further violates this Takings Clause. (*Id.* ¶ 37, emphasis added)
>
> In addition, the Act violates this Takings Clause by transferring property from one private group (physicians) to other private entities, namely insurance companies, in the form of the latter's ***underpayment for services***. (*Id.* ¶ 38, emphasis added)
>
> By compelling out-of-network physicians to participate in arbitration as required by the Act, ***Plaintiff's members are further deprived of just compensation for the services that they rendered***. (*Id.* ¶ 39, emphasis added)

The foregoing allegations, which must be taken as true with all reasonable inferences drawn therefrom in favor of Plaintiff, plainly do establish that some members of Plaintiff "will not be reasonably reimbursed for their services (either through the Act's reimbursement methodology or the dispute resolution process)." (Defs Mem. 9)

In addition, Defendants' solitary authority is easily distinguishable. In *Schmier*, the allegation of standing was based on an assertion by a plaintiff that litigants and lawyers had a vague interest in being allowed to cite to unpublished opinions, but the plaintiff could not point to any financial or otherwise legally cognizable harm arising

from a Ninth Circuit rule that prohibited citing unpublished opinions as authority. 279 F.3d at 820-21. Unlike here, in *Schmier* the plaintiff was not an association and he could not point to any financial harm. Indeed, the plaintiff in *Schmier* "has not alleged a violation of a right personal to himself; rather, he appears to allege an injury on behalf of all lawyers practicing within the Ninth Circuit." *Id.* at 821. There standing was lacking because an individual litigant cannot merely assert a vague claim on behalf of others who are not even part of an association and who have no alleged cognizable injury. *See, e.g.*, *Loritz v. United States Court of Appeals for the Ninth Circuit*, 382 F.3d 990, 992 (9th Cir. 2004) (standing does not exist to allege a violation of rights of potential future litigants who might prefer to cite an unpublished decision in a plaintiff's case). If the plaintiff *Schmier* had alleged that the Ninth Circuit "ha[d] adversely affected one or more of Schmier's clients in a Ninth Circuit litigation," then he may have had standing, the Ninth Circuit held. *Id.* 279 F.3d at 822. Plaintiff alleges more than that here.

Plaintiff AAPS also fully satisfies "the concrete injury-in-fact, causation, and redressability requirements for standing." *WildEarth Guardians*, 795 F.3d 1148, 1155 (9th Cir. 2015). Unlike the cases where there are legitimate doubts about standing, here the financial harm to members of Plaintiff AAPS is obvious and alleged in detail, as quoted above from the Complaint. For example, Plaintiff alleges that its members are being subjected to "confiscatory" reimbursement rates under AB 72 as payment on the out-of-network services they provide. (Compl. ¶ 29, 37) An invalidation of AB 72 would alleviate that financial harm and restore the out-of-network billings, for submission to insurance companies by Dr. Couris and other members of AAPS, to a reasonable level more commensurate with their investments made for their skills.

Defendants further argue that "plaintiff has alleged no facts showing why any real or even perceived obstacle prevents its members from suing on their own behalf should a billing issue arise in the future." (Defs Mem. 10) But the mandatory arbitration imposed by AB 72 does precisely that: it impedes the ability of an AAPS member or any individual physician from suing directly to overturn AB 72. Plaintiff itself is not so

limited by AB 72, and its arguments for associational standing are compelling here. *See, e.g.*, *Int'l Union v. Brock*, 477 U.S. 274, 290 (1986) ("the doctrine of associational standing recognizes that the primary reason people join an organization is often to create an effective vehicle for vindicating interests that they share with others").

The Ninth Circuit simply does not impose an overly demanding requirement of associational standing as sought by Defendants. As the Ninth Circuit recently held in reversing dismissal of a complaint for supposed lack of associational standing:

> Where it is relatively clear, rather than merely speculative, that one or more members have been or will be adversely affected by a defendant's action, and where the defendant need not know the identity of a particular member to understand and respond to an organization's claim of injury, we see no purpose to be served by requiring an organization to identify by name the member or members injured.

Nat'l Council of La Raza v. Cegavske, 800 F.3d 1032, 1041 (9th Cir. 2015). Under Ninth Circuit caselaw, Plaintiff's allegations of associational standing here are sufficient.

IV. Plaintiff Has Standing to Bring this Action on Behalf of Its Members' Unnamed Patients.

Only Plaintiff AAPS's constitutional claim based on the Equal Protection Clause, U.S. CONST. AMEND. XIV, § 1, requires "third-party standing," which admittedly is more difficult to establish than associational standing is. Defendants contest the ability of Plaintiff AAPS, as a physician's organization, to assert an equal protection claim on behalf of *patients*. Defendants state the requirement for asserting third-party standing based on injury to third parties, who are patients of physician-members of AAPS here. (Defs Mem. 10, citing *Powers v. Ohio*, 499 U.S. 400, 410-411 (1991)).

But it is the systemic effect of AB 72 that is objectionable in conferring benefits on private insurance companies, at the expense of physicians and to the detriment of their uninsured patient populations. AB 72 discriminates against the uninsured patients by making it more difficult or impossible for out-of-network physicians to care for them. Just as an end to the free market would sharply reduce charitable giving, the elimination of free-market out-of-network billing by AB 72 compels those physicians to forgo charity

care for the uninsured. Stated another way, AB 72 benefits insurance companies and discriminates against those outside of insurance, including uninsured patients. These "hidden" victims of AB 72 – the uninsured – are disproportionately minorities, and there is an equal protection violation in how AB 72 prefers insurance companies to them.

This claim by Plaintiff fits squarely within U.S. Supreme Court precedent for asserting third-party standing. *See Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 628-29 (1991) (allowing litigants to assert the rights of jurors excluded based on race).

Physician-members of Plaintiff AAPS plainly have suffered "injury in fact" from AB 72, and the physicians certainly have a close relationship with their own patients, both insured and uninsured. Uninsured patients are obviously unable to assert their claims on their own behalf. While Plaintiff's equal protection claim here is somewhat novel, it would be premature to dismiss it at this pleading stage without further factual development. Construing the allegations as true and drawing all inferences in favor of Plaintiff, as this Court must on Defendants' motion on the pleadings, Plaintiff's claim for the equal protection violation should survive.

V. AB 72 Violates the Equal Protection Guarantee of the United States Constitution.

It is widely recognized that price controls result in rationing, by reducing the supply of the service for which the prices are artificially reduced. "[D]uring any emergency, price control and rationing will merge into any attempt at allocation of materials and facilities." *United States v. Elade Realty Corp.*, 66 F. Supp. 630, 634 (1946), *aff'd*, 157 F.2d 979 (2d Cir. 1946). Whether the alleged existence of "surprise medical bills" constitutes an emergency justifying extraordinary price controls and rationing by the government is an issue of fact unsuitable for Defendants' motion for judgment on the pleadings. Defendants assert that there is no violation of equal protection caused by its price controls, but that argument does not withstand scrutiny once Plaintiff's allegations are taken to be true, as they must be on Defendants' motion for judgment on the pleadings. (Defs Mem. 11-14)

In reversing a claim for violation by a facially neutral regulation of the Equal Protection Clause, the Ninth Circuit emphasized that "[i]t is too early in the course of this litigation, then, to determine whether the defendants' conduct was free from discriminatory purpose" that might violate that fundamental constitutional safeguard. *De La Cruz v. Tormey*, 582 F.2d 45, 59 (9th Cir. 1978). Health care service plan providers do not insure many in the underserved minority community, and "physicians are coerced by the Act to withdraw services from predominantly minority communities." (Compl. ¶ 5) AB 72 reduces the availability of physicians, including members of AAPS to serve the uninsured community. (*Id.* ¶¶ 8, 46-48)

Defendants argue that the rational-basis standard of review should apply (Defs Mem. 13), but even if it does, the most onerous provisions of AB 72 do not even satisfy that undemanding standard. Requiring patients and physicians to agree to a detailed, multi-point set of requirements in order for physicians to provide out-of-network care to patients, as AB 72 does, *see* Cal. Health & Saf. Code § 1371.9(a)(1)-(6), has no plausible rational justification in the stated purpose of eliminating surprise medical bills. Requiring transparency or prohibiting collection against patients – but not banning collection from insurance companies – would accomplish the stated goals of AB 72.

VI. AB 72 Violates the Due Process Guarantee of the United States Constitution.

"Congress may employ private entities for *ministerial* or *advisory* roles, but it may not give these entities governmental power over others. We agree that this articulation accurately summarizes the Supreme Court's holdings." *Pittston Co. v. United States*, Nos. 02-2199, 02-2200, 03-1351, 03-1354, 2004 U.S. App. LEXIS 16730, at *18 (4th Cir. May 18, 2004).

The U.S. Court of Appeals for the D.C. Circuit has explained and applied this concept to invalidate a delegation of regulatory authority to Amtrak. *See Ass'n of Am. R.R. v. United States DOT*, 721 F.3d 666 (2013), *rev'd on other gnds*, *DOT v. Ass'n of Am. R.R.*, 135 S. Ct. 1225 (2015). There the D.C. Circuit held that "a flexible

Constitution must not be so yielding as to become twisted. Unless it can be established that Amtrak is an organ of the government, therefore, [the challenged federal law] is an unconstitutional delegation of regulatory power to a private party." 721 F.3d at 674. The D.C. Circuit distinguished cases upholding the delegation of regulatory power to private entities on the ground that those schemes were "contingent upon the assent of a certain portion of the regulated industry," or concerned "purely advisory or ministerial functions," and never authorized "a private party [to] stand on equal footing with a government agency" as private insurance companies are empowered by AB 72 to do. *Id.* at 671 n.5. The court observed, without basing its decision on this ground, that the "doctrine forbidding delegation of public power to private groups is, in fact, rooted in a prohibition against self-interested regulation that sounds more in the Due Process Clause than in the separation of powers." 721 F.3d at 671 n.3 (quoting A. Michael Froomkin, *Wrong Turn in Cyberspace: Using ICANN To Route Around the APA and the Constitution*, 50 Duke L.J. 17, 153 (2000)).

Here, AB 72 impermissibly gives insurance companies "governmental power" over others by allowing insurance companies to establish a default reimbursement rate for physicians who have no relationship with the insurance companies.[4]

VII. AB 72's Reimbursement Provisions Are Not Consistent With Substantive Due Process Principles.

In *Carter v. Carter Coal Co.*, a case cited favorably by hundreds of other rulings, including many in recent years, the U.S. Supreme Court emphasized that a legislature may not delegate regulatory power to a private entity:

> [A] statute which attempts to confer such power undertakes an intolerable and unconstitutional interference with personal liberty and private property. The delegation is so clearly arbitrary, and so clearly a denial of rights safeguarded by the due process clause of the Fifth Amendment, that it is unnecessary to do more than refer to decisions of this court which foreclose the question.

[4] Defendants object to this Court hearing the state law objections to AB 72, but Defendants concede that the U.S. Constitution provides virtually identical safeguards and thus Defendants' objection is not an obstacle to Plaintiff's federal claims being allowed in this Court on the same arguments. (Defs Mem. 11 n.2, 14 n.3)

Carter v. Carter Coal Co., 298 U.S. 238, 311-12 (1936) (citing multiple precedents).

A. Even If Limited, AB 72 Is Still Unconstitutional.

In a terse three-sentence section, Defendants argue that "[t]he Act is not as broad-based as plaintiff suggests." (Defs Mem. 15) Exemptions and narrowing interpretations of AB 72 are welcome, but Defendants' limiting implementation is still unconstitutional.

Moreover, even a limited scope of AB 72 has a rippling effect on all reimbursements, by removing most negotiating leverage from physicians in dealing with health care service plan providers. AB 72 gives the plan providers the ability to say "take it or leave it" with respect to their in-network pricing, and under AB 72 there is nowhere else for physicians to go. The Act creates a situation akin to professional sports fifty years ago, when owners took all the profits and paid star players so little that they had difficulty making ends meet financially. Many physicians will retire early or move out-of-state rather than be saddled with the 125% of the declining Medicare rates that AB 72 authorizes health care service plan providers to limit all their reimbursements to.

B. The Reimbursement Rates Are Not Flexible.

AB 72 imposes the equivalent of an absolute limit on charges – 125 percent of Medicare – and absolute limits have repeatedly been held to be unconstitutional in the rent control context. *See, e.g.*, *Kavanau v. Santa Monica Rent Control Bd.*, 19 Cal. App. 4th 730, 732, 735, 23 Cal. Rptr. 2d 724, 725, 727 (1993) (holding as unconstitutional an "absolute limitation on annual rental increases," and compiling similar authorities).

For example, "even a generous 25%" annual rent control limit is arbitrary and unconstitutional because it inflexibly fails "to insure a fair return" in all circumstances. *Cromwell Assocs. v. Newark*, 211 N.J. Super. 462, 467, 471, 511 A.2d 1273, 1275, 1277 (Super. Ct. 1985) (holding that "[t]he amendment to the Newark rent-control ordinance fails to comply with constitutional requisites" of flexibility for ensuring a fair return) (cited favorably by *Kavanau*, 19 Cal. App. 4th at 735, 23 Cal. Rptr. 2d at 727).

Defendants argue that the reimbursement rates set by AB 72 are "flexible". (Defs Mem. 15-16) Defendants insists that plan providers could agree to pay more, but why

would they when AB 72 authorizes them to set rates? No insurer would. Defendants' argument is a bit like saying professional athletes do not need free agency because any owner could agree with a player to pay him more. AB 72 gives insurers the incentive to decrease reimbursement rates to only 125 percent of Medicare. Defendants insist that by January 1, 2019, the Department of Managed Health Care will develop a methodology for health care plan providers to use. But this merely confirms the constitutional defect in allowing private companies to set reimbursement rates in 2017 and 2018 on their own without proper governmental involvement and accountability in these current years.

There is no accommodation in AB 72 to allow physicians and other medical care professionals to obtain "a just and reasonable return on their" investments in their careers, which is often enormous. *Kavanau*, 19 Cal. App. 4th at 734-35, 23 Cal. Rptr. 2d at 727. There is no accommodation in AB 72 for inflation, rising tuition and costs for medical training, or reductions in Medicare rates, and such inflexibility is unconstitutional.

C. The Reimbursement Rates Are Confiscatory.

Medicare reimbursement rates are widely known to be below cost for many services, which is why so many physicians decline to accept Medicare. Senator Larry Craig (R-ID) declared two decades ago, as recorded in the Congressional Record:

> At or below-cost reimbursement rates have made it difficult to recruit new physicians in my State of Idaho and have forced many doctors to limit the number of Medicare patients they will treat.

PRESERVE MEDICARE, 141 Cong Rec S 11715, 11715 (August 7, 1995). Medicare reimbursement rates are even lower for many services today, thereby making Senator Craig's observation even more compelling now.

AB 72 provides no mechanism for physicians to seek an increase above reimbursement levels that may be confiscatory for certain services, and under rent-control precedents this is unconstitutional. "We therefore hold that because Regulation No. 4005, subdivision (a)(8) could have unconstitutional results in particular cases, the trial court was correct in staying its enforcement." *Apartment Assn. of Greater L.A. v. Santa*

Monica Rent Control Bd., 24 Cal. App. 4th 1730, 1739, 30 Cal. Rptr. 2d 228, 232-33 (1994) (citing *Birkenfeld v. Berkeley*, 17 Cal. 3d 129, 165, 169, 130 Cal. Rptr. 465, 550 P.2d 1001 (1976)). At a minimum, this presents an issue of fact.

D. AB 72 Does Not Satisfy the Rational Basis Standard.

The delegation of price-setting authority by AB 72 to private companies does not satisfy the rational basis standard, and is not justified by the alleged purpose of eliminating "surprise billing." The stated goal of ending surprise billing can easily be achieved by requiring price transparency and informed billing consent. None of this justifies authorizing private companies to set reimbursement rates for physicians who have no contractual relationship with the companies. AB 72 lacks a rational basis by imposing that draconian change in the law.

Defendants argue that AB 72 protects against surprise medical bills and allows for fair reimbursement. (Defs Mem. 17) But nothing in AB 72 ensures a fair rate of reimbursement for physicians. To the contrary, AB 72 ensures greater profits for insurance companies by allowing them to set prices as low as 125 percent of Medicare, which can even be below the cost of the services rendered, and is often not a fair return on the enormous investments made by physicians and other medical care professionals in their careers. At a minimum, there is an issue of fact that precludes judgment now.

VIII. AB 72's Independent Dispute Resolution Process Is Inconsistent With Procedural Due Process Guarantees.

Defendants clarify their view that judicial remedies are still available under AB 72, but only after there is completion of an extraordinary, costly arbitration proceeding by the parties. Similar mandatory arbitration provisions have been stricken by courts. *See, e.g.*, *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 235 n.3, 104 S. Ct. 2321, 2326 (1984) ("The District Court declared both the compulsory arbitration provision and the compensation formulae unconstitutional.").

Piecemeal, time-consuming arbitration over individual fees is not an adequate remedy for relief from across-the-board confiscatory rates. When insurance companies

faced confiscatory rates imposed by the State against them, the insurance companies obtained invalidation of the confiscatory rates by the Ninth Circuit in part because the remedies were "unsatisfactory to provide relief from rates set by statute." *Guar. Nat'l Ins. Co. v. Gates*, 916 F.2d 508, 516 (9th Cir. 1990). What is good for the goose is good for the gander, and victims of confiscatory rates imposed by insurance companies under AB 72 have a constitutional right to an adequate remedy.

IX. AB 72 Violates the Takings Clause.

"The Takings Clause applies as well to government enactments that, while not direct appropriations or ousters, are equivalent thereto. These enactments have been called regulatory takings …." *Small Prop. Owners of San Francisco v. City & Cty. of San Francisco,* 141 Cal. App. 4th 1388, 1396-97, 47 Cal. Rptr. 3d 121 (2006) (finding a regulatory taking in a regulation that landlords must pay 3% interest on security deposits). That case was decided under the Takings Clause of the Fifth Amendment of the U.S. Constitution, U.S. CONST. AMEND. V, and California courts generally construe the federal and California takings clauses synonymously. *See San Remo Hotel v. City and County of San* Francisco, 27 Cal.4th 643, 664, 117 Cal. Rptr. 2d 269, 41 P.3d 87 (2002); *San Remo Hotel v. County of San Francisco*, 545 U.S. 323, 337 n.18 (2005) (stating and assuming "that the California Supreme Court was correct in its determination that California takings law is coextensive with federal law").

AB 72 compels the transfer of property – the fair market value for compensation for services rendered – from the out-of-network physicians who rendered the services for the benefit of private companies that would otherwise be required to pay in full for the services. This is an unconstitutional taking, as made clear by rent control cases.

An example helps illustrate the takings, and how improper it is. Suppose California were to enact a law prohibiting any restaurants from charging more than the 125% of the price of a McDonald's hamburger. That would constitute a transfer in property from expensive restaurants to customers in the amount of the fair market value for gourmet hamburgers, minus the 125% price for a McDonald's hamburger. Such a

law would be an unconstitutional taking from high-level restaurants, and the law would be invalidated. It allowed, it would result in less supply of gourmet hamburgers.

Here, wealthy insurance companies are the beneficiaries of the takings imposed by AB 72. The insurance companies sign up patients by promising to reimburse them for their medical expenses in covered facilities. The patients reasonably expect that their insurance companies will pay any out-of-network bills that may arise. In the absence of AB 72, insurance companies would be required to pay a fair market value for the out-of-network services rendered. Instead, AB 72 gives insurance companies a windfall by authorizing them to reduce their obligations to only 125% of Medicare.

"A small taking is still a taking." *Action Apartment Ass'n v. Santa Monica Rent Control Bd.*, 94 Cal. App. 4th 587, 606, 114 Cal. Rptr. 2d 412, 426 (2001). The *Action Apartment Ass'n* decision held that allegations concerning a Santa Monica ordinance requiring landlords to pay three (3) percent on the security deposits by tenants was a valid takings claim. Here, AB 72 essentially requires physicians to transfer to health care service plan providers the difference between the fair market value of their services and 125% of Medicare (or the prevailing in-network rate). Whether that difference is large or small, there is a valid cause of action for an unconstitutional taking in requiring the transfer of that value by physicians to plan providers. Defendants' motion must be denied.

X. For Patients Having Both Medicare and Insurance Coverage, AB 72 Is Preempted by Federal Law.

Federal law and regulations establish that physicians can opt out of Medicare and then contract privately with patients pursuant to federal regulations, without restriction as to prevailing Medicare or health care plan provider reimbursement rates. Section 1802 of the Social Security Act, as amended by §4507 of the Balanced Budget Amendment of 1997, authorizes this private billing. 42 U.S.C. § 1395a; *see also* 42 CFR § 405.405, *et seq*. Under federal law, Medicare-eligible patients are entirely free to enter into agreements with physicians for treatment without constraint by Medicare or insurance

reimbursement rates. This federal law preempts AB 72 for the large Medicare population. "Put simply, federal law preempts contrary state law." *Hughes v. Talen Energy Mktg.*, 136 S. Ct. 1288, 1297 (2016). AB 72 is unenforceable for this reason.

XI. Leave to Amend Should Be Granted If Any Deficiencies Are Found in the Complaint.

"[T]he court cannot say that it would be wholly futile for the plaintiff to amend his Fourteenth Amendment claim to allege an actionable substantive-due-process violation. Insofar as the present Fourteenth Amendment claim does allege such a violation, the court dismisses it with leave to amend." *Leon v. Hayward Bldg. Dep't*, No. 17-cv-02720-LB, 2017 U.S. Dist. LEXIS 120006, at *13 (N.D. Cal. July 31, 2017).

"It is black-letter law that a district court must give plaintiffs at least one chance to amend a deficient complaint, absent a clear showing that amendment would be futile." *Nat'l Council of La Raza v. Cegavske*, 800 F.3d 1032, 1041 (9th Cir. 2015). "Dismissal with prejudice and without leave to amend is not appropriate unless it is clear on de novo review that the complaint could not be saved by amendment." *Eminence Capital, LLC v. Aspeon, Inc.*, 316 F.3d 1048, 1052 (9th Cir. 2003). "In the absence of any apparent or declared reason—such as undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of allowance of the amendment, futility of amendment, etc.—the leave sought should, as the [Federal Rules of Civil Procedure] require, be 'freely given.'" *Foman v. Davis*, 371 U.S. 178, 182 (1962).

The U.S. Supreme Court recently held that a membership organization should have the opportunity to submit evidence to bolster its claim of associational standing. *Alabama Legislative Black Caucus v. Alabama*, 135 S. Ct. 1257, 1269-70 (2015). Likewise, leave to amend should be granted here if any deficiencies are found.

Conclusion

For the foregoing reasons, Defendants' motion should be denied in its entirety. Plaintiff respectfully requests the right to amend to cure any deficiencies if so found.

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Respectfully submitted,

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