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

ASSOCIATION OF AMERICAN PHYSICIANS & SURGEONS, INC., AND EILEEN NATUZZI, M.D., Plaintiffs, vs. SHELLEY ROUILLARD, in her official capacity as as the Director of the California Department Managed Health Care, Defendant.	) 2:16-cv-02441-MCE-EFB))) **PLAINTIFFS' MEMORANDUM OF POINTS AND AUTHORITIES ON THE ISSUE OF AB 72 AND MEDICARE**))) Ctrm: 7) Judge: Hon. Morrison C. England, Jr.) Hearing: Mar. 7, 2019, 2pm) Case filed: Oct. 13, 2016

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Plaintiffs Association of American Physicians & Surgeons, Inc. ("AAPS") and Eileen Natuzzi, M.D. (collectively, "Plaintiffs") hereby file their Memorandum of Points and Authorities on the issue of AB 72 and Medicare, as directed by this Court. [D.E. 38]

Introduction

California Assembly Bill 72 ("AB 72" or the "Act") restricts and even prohibits private contracting by physicians with patients. But for Medicare patients – who form a substantial percentage of patients subject to AB 72 – private contracting is a right which is regulated by federal law. AB 72 conflicts with federal law, and is preempted by it, concerning the rights of these patients and their physicians, including members of AAPS, with respect to Medicare supplemental insurance policies.

Under federal law, Medicare enrollees and physicians may agree to private contracts for payment pursuant to federal regulations. But AB 72 prohibits such payments unless there is compliance with a different, more burdensome set of requirements. Defendant Shelley Rouillard ("Defendant") should be enjoined against the application of AB 72 to Medicare supplemental insurance ("Medigap") policies because AB 72 conflicts with federal law. There is no severability clause in AB 72, and thus it should be invalidated in its entirely.

Statement of Facts Relevant to Medicare and Medigap

California Assembly Bill No. 72 (the "Act" or "AB 72") was signed into law on September 23, 2016, and became effective on July 1, 2017. (Am. Compl. ¶ 1)

AB 72 prohibits private contractual arrangements between physicians and patients who have insurance coverage such as Medigap. "[I]f an enrollee receives covered services from a contracting health facility at which, or as a result of which, the enrollee receives services provided by a noncontracting individual health professional, the

enrollee shall pay no more than the same cost sharing that the enrollee would pay for the same covered services received from a contracting individual health professional"; the noncontracting physician "shall not bill or collect any amount from the enrollee for services subject to this section except for the in-network cost-sharing amount." The Act § 3(a)(1)&(3) (adding Section 1371.9(a)(1)&(3) to the California Health and Safety Code). (Am. Compl. ¶ 40)

AB 72 thereby interferes with physicians who are enrolled as "nonparticipating" in Medicare and likewise impedes those physicians who are "opted out" of Medicare. These are two different categories of physicians, both of whom are allowed by federal law to charge the patient more than the Medicare-authorized rates for Medicare-enrolled, participating physicians. Under federal law, physicians who are either non-participating or opted out under Medicare may enter into private contracts with Medicare-enrolled patients for private payment for services rendered, pursuant to federal regulations. (*Id.* ¶ 13) But AB 72 prohibits these physicians from receiving private payments from Medicare-enrolled patients for services provided at in-network facilities, unless the very different and far more burdensome consent requirements of AB 72 are satisfied. (*Id.*) These non-participating or opted-out physicians are prevented from billing or collecting from Medicare enrollees, including patients having Medicare Advantage or Medigap plans, any fee other than "the in-network cost-sharing amount," or Medicare-approved fee. The Act § 3(a)(3).

Application of the foregoing requirements of AB 72 thereby violates federal law by impinging upon the ability of Medicare non-participating or opted-out physicians to receive payment for services rendered at hospitals that participate in Medicare, as

virtually all hospitals do. (Am. Compl. ¶¶ 38, 41) AB 72 lacks a severability clause that would allow severing and striking the portion that conflicts with federal law in order to save the remainder of the statute. (*Id.* ¶ 43)

Argument

This Court directs the parties to address the following three issues:

(1) whether the Act applies to Medicare enrollees;

(2) whether Medigap entitles enrollees to benefits separate and apart from their Medicare policy such that they may be considered covered services under the Act; and

(3) assuming a conflict has been alleged, whether Plaintiffs have a claim in equity.

Each of these issues is addressed below.

I. AB 72 Applies to Medicare Enrollees, Thereby Creating a Conflict with Federal Law Concerning Private Contracting.

AB 72 applies to Medicare enrollees, which is a significant percentage of the patient population subject to AB 72. Medicare enrollees constitute nearly half of all hospital admissions.[1] (Am. Compl. ¶ 13)

AB 72 does not contain any language indicating any inapplicability to Medicare enrollees. AB 72 does contain provisions stating that it does not apply to Medi-Cal, but that is the California Medicaid program for the medically indigent, which is very different from the federal Medicare program. There is also language in other sections of California law governing health care service plans which disclaim any application to Medicare (or Medicare supplemental insurance), but such provisions are not in AB 72.

[1] https://www.debt.org/medical/hospital-surgery-costs/ (viewed 2/17/19) ("Medicare pays 90 percent of the costs for almost 42 percent of " patients admitted each year to U.S. hospitals).

By expressly excluding Medi-Cal while containing no such exclusion of Medicare, AB 72 thereby fully applies to Medicare enrollees. Non-participating and opted-out physicians are authorized by federal law to enter into private contracts with these patients without the regulations and bans on billing imposed by AB 72.

The federal law applies broadly to all services provided to all patients who are enrolled in Medicare, which necessarily includes all patients enrolled in Medigap too. The federal preemption applies more broadly than to specific Medigap plans themselves, because the federal preemption applies to every patient enrolled in Medicare and to every plan, Medicare or private, which may cover their medical services.

In addition, as this question posed by the Court is not limited to Medigap plans but includes all Medicare enrollees, it is worth pointing out that Medicare Advantage patients are also Medicare enrollees who are fully subject to AB 72, which infringes on their right to enter into private contracts with opted-out physicians. Under Medicare Advantage, the Medicare program pays private companies to provide Medicare benefits.[2] Patients enrolled in Medicare Advantage plans are allowed under federal regulations to contract privately with opted-out physicians, just as ordinary Medicare enrollees are. But in conflict with the federal scheme, AB 72 prohibits such private contracts for surgeries done at facilities which accept Medicare, which is virtually all facilities. "An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section." The Act § 3(a)(2) (adding Section 1371.9(a)(2) to the California Health and Safety Code).

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[2] https://www.medicare.gov/pubs/pdf/11474.pdf (viewed 2/18/19) ("Medicare Advantage Plans, sometimes called "Part C" or "MA Plans," are offered by private companies approved by Medicare. Medicare pays these companies to cover your Medicare benefits.").

Accordingly, if an opted-out physician treats a Medicare Advantage patient at a facility that is in-network with Medicare Advantage, the opted-out physician could collect no more from that patient than the patient's cost sharing amount when receiving the services from a physician contracted with the Medicare Advantage plan. In addition, the opted-out physician is prohibited by AB 72 from collecting any additional payment from the Medicare Advantage plan; he is prohibited from doing that because he is opted out of Medicare. Under AB 72 the physician could collect only the patient's cost sharing amount and nothing more, in conflict with federal law.

"Put simply, federal law preempts contrary state law." *Hughes v. Talen Energy Mktg.*, 136 S. Ct. 1288, 1297 (2016). AB 72 is thereby unenforceable as inconsistent with federal Medicare law. Moreover, AB 72 lacks a severability clause that would allow severing and invalidating the portion that conflicts with federal law, in order to save the remainder of the statute. (Am. Compl. ¶ 43) If the lack of an exemption from application of AB 72 to Medicare is in conflict with federal law concerning the right to contract privately with Medicare enrollees, 42 U.S.C.S. § 1395a (establishing a "Basic freedom of choice" for patients), then enforcement of the entirety of AB 72 must be enjoined.

II. Medigap Policies Do Sometimes Entitle Enrollees to Benefits Separate and Apart from Their Medicare Policy, such that They May Be Considered Covered Services under the Act.

Medigap plans are popular private insurance policies certified by the federal government and regulated by the States.[3] In California, "Medigap" is defined to include all Medicare supplemental insurance policies. "To purchase Medicare Supplement

[3] https://www.kff.org/medicare/issue-brief/medigap-enrollment-and-consumer-protections-vary-across-states/ (viewed 2/17/19) ("One in four people in traditional

Insurance you must be enrolled in Medicare Part A and Part B. Medicare Supplement Insurance (also known as Medigap) ***provides coverage for gaps in medical costs not covered by Medicare***." *See* Official Website of the California Department of Insurance (emphasis added).[4] There is a requirement that a patient be an enrollee of Medicare in order to purchase Medigap policies, but the policies themselves are offered by the private sector to pay costs beyond what the Medicare program pays.

The federal government defines Medicare Supplemental Health Insurance Policies in this federal statute, which references their Certification:

> CERTIFICATION OF MEDICARE SUPPLEMENTAL HEALTH INSURANCE POLICIES
>
> (g)(1) For purposes of this section, a medicare supplemental policy is a health insurance policy or other health benefit plan offered by a private entity to individuals who are entitled to have payment made under this title, which provides reimbursement for expenses incurred for services and items for which payment may be made under this title but which are not reimbursable by reason of the applicability of deductibles, coinsurance amounts, or other limitations imposed pursuant to this title;

42 U.S.C. 1395ss(g)(1).[5] The Ninth Circuit has defined Medigap policies the same way: "Medigap policies offer supplemental private health insurance ***to cover costs not covered by Medicare***." *Friedman v. AARP, Inc.*, 855 F.3d 1047, 1049 (9th Cir. 2017) (emphasis added).

For the purposes of Plaintiffs' challenge here to AB 72, there are two different types of private contracting that can be reimbursed by Medicare supplemental insurance (Medigap) policies pursuant to the federal statutory framework. In one type of situation

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Medicare (25 percent) had private, supplemental health insurance in 2015—also known as Medigap ….").

[4] http://www.insurance.ca.gov/0150-seniors/0300healthplans/index.cfm (viewed 2/17/19).

[5] https://www.ssa.gov/OP_Home/ssact/title18/1882.htm (viewed 2/17/19).

the physician is enrolled as "non-participating" in the Medicare program and thus takes payment directly from the patient. The patient receives some reimbursement from the Medicare program and there are federal limits higher than the Medicare participating rates on what the physician may charge. The "excess charge" is defined as the amount above the Medicare rate which this type of physician is allowed by federal law to charge the patient.

The other situation is when the physician is opted out of Medicare. He also takes payment directly from the patient, but the patient does not receive any reimbursement from the Medicare program for these services, and there are no limits on what the physician may charge. Instead, the physician is subject to a federal regulatory scheme which dictates the terms of the private contracts between the physician and the patients.

Medicare supplemental insurance policies (Medigap) may, but are not required to, create entitlements for either or both situations. Medicare supplemental insurance is offered by the private sector and thus can come in many varieties as in any other free market. It is a result of supply-and-demand, and thus ***the answer to the question posed by the Court is that Medigap "may" rather than "must" provide reimbursement for the foregoing services which are not reimbursed by the Medicare program***.

On a federal Centers for Medicare & Medicaid (CMS) government website, it posts a manual entitled "2017 Choosing a Medigap Policy: A Guide to Health Insurance for People with Medicare."[6] In its manual the federal government defines:

> **Excess charge**—If you have Original Medicare, and the amount a doctor or other health care provider is legally permitted to charge is higher than the Medicare-approved amount, the difference is called the excess charge.

[6] https://www.medicare.gov/sites/default/files/2018-07/02110-medicare-medigap.guide_.pdf (viewed 2/17/19).

Id. at p. 49. Medigap policies are expressly allowed by the federal government to pay for the "excess charge" as an Optional Rider to the policy. *Id.* at p. 44.

AB 72 conflicts with this federal scheme. AB 72 applies to all physicians, including those who are enrolled as non-participating in Medicare, and those who are opted out of Medicare. In both situations some Medigap policies may provide reimbursement to patients under federal law. But AB 72 prohibits some of that reimbursement unless the physician departs from the federal Medicare regulations and instead complies with the different AB 72 regulations. AB 72 prohibits physicians in the foregoing categories from billing the patients above the Medicare-participating rates even though the physician is in full compliance with the applicable federal law. This constitutes an impermissible conflict by AB 72 with federal law.

III. Plaintiffs Have a Claim in Equity Here to Address the Conflict.

Plaintiffs lack an adequate remedy at law for the conflict between AB 72 and federal rules, namely the Medicare regulations concerning private contracting. In this absence of an adequate remedy at law, Plaintiffs' claim arises in equity. *See, e.g.*, *Ex parte Young*, 209 U.S. 123, 155-56, 28 S. Ct. 441, 452 (1908) ("The various authorities we have referred to furnish ample justification for the assertion that individuals, who, as officers of the State, are clothed with some duty in regard to the enforcement of the laws of the State … ***may be enjoined by a Federal court of equity*** from such action.") (emphasis added).

As the Ninth Circuit recently explained:

> [P]laintiffs do not need a statutory cause of action. They can rely on the judge-made cause of action recognized in *Ex parte Young*, 209 U.S. 123, 28 S. Ct. 441, 52 L. Ed. 714 (1908), which permits courts of equity to enjoin enforcement of state statutes that violate the Constitution ***or conflict with other federal laws***. *See*

> *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378, 1384, 191 L. Ed. 2d 471 (2015).

Moore v. Urquhart, 899 F.3d 1094, 1103 (9th Cir. 2018) (emphasis added).

This is consistent with the broad equitable powers of federal courts on other issues. *See, e.g.*, *Century 21 Real Estate Corp. v. Sandlin*, 846 F.2d 1175, 1180 (9th Cir. 1988) ("[I]njunctive relief is the remedy of choice for trademark and unfair competition cases, since there is no adequate remedy at law for the injury caused by a defendant's continuing infringement."). *See also Marshall Leasing v. United States*, 893 F.2d 1096, 1101 (9th Cir. 1990) ("The district court should not refuse jurisdiction over an equitable claim on the ground that there is an adequate remedy at law unless there is a forum in which the claim for monetary damages can be heard."); *Jamerson v. All. Ins. Co.*, 87 F.2d 253, 256 (7th Cir. 1937) ("It is axiomatic that equitable jurisdiction exists to cancel insurance policies, even after loss, where, because of special circumstances, the remedy at law is inadequate.").

Physicians face an irreconcilable conflict between federal law and AB 72 with respect to Medicare enrollees. There is no remedy at law for this conflict, other than invalidating AB 72 in its entirety. In the absence of striking down AB 72, Plaintiffs have a claim in equity for which they cannot obtain an adequate remedy at law.

Conclusion

For the foregoing reasons, there remain genuine issues of material fact about AB 72, and Defendant's pending motion to dismiss should be denied in its entirety.

Dated: February 19, 2019

Respectfully submitted,

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Certificate of Service

I, Andrew L. Schlafly, counsel for Plaintiff Association of American Physicians & Surgeons, Inc., and Eileen Natuzzi, M.D., do certify that on February 19, 2019, I electronically filed the foregoing Plaintiffs' Memorandum of Points and Authorities on the Issue of AB 72 and Medicare using the Electronic Case Filing system, which I understand to have caused electronic service on all parties that have appeared in this matter.

/s/ Andrew L. Schlafly
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