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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 IN**) **OPPOSITION TO THE**) **MOTION TO DISMISS**))) Ctrm: 7) Judge: Hon. Morrison C. England, Jr.) Trial date:) Case filed: Oct. 13, 2016

TABLE OF CONTENTS

Table of Contents ii

Table of Citations iii

Introduction 1

Statement of Facts 2

Legal Standard 7

Argument 8

I. Plaintiffs, Who Include Members of an Association and an Individual Physician Who Has Been Injured by AB 72, Have Standing. 8

II. Plaintiffs State a Valid Due Process Claim, as *Bell v. Blue Cross* Establishes that It Violates the Constitution to Prohibit Out-of-Network Compensation at Out-of-Network Rates. 10

III. Plaintiffs State a Valid Takings Claim. 12

IV. Plaintiffs State a Valid Cause of Action to Enjoin Defendant from Violating Federal Law concerning Contracts with Medicare Patients. 14

A. Federal Law Preempts AB 72 with respect to the Large Medicare Population. 15

B. Plaintiffs Have a Valid Cause of Action Regardless of whether the Supremacy Clause Creates an Independent Private Right. 18

Conclusion 20

Certificate of Service 21

TABLE OF CITATIONS

CASES

Action Apartment Ass'n v. Santa Monica Rent Control Bd., 94 Cal. App. 4th 587, 114 Cal. Rptr. 2d 412 (2001) 13

All. of Nonprofits for Ins., Risk Retention Grp. v. Kipper, 712 F.3d 1316 (9th Cir. 2013) 19-20

Armstrong v. Exceptional Child Ctr., Inc., 135 S. Ct. 1378 (2015) 18, 19, 20

Bell v. Blue Cross of Cal., 131 Cal. App. 4th 211, 31 Cal. Rptr. 3d 688 (2005) ..... ii, 10, 11, 12

Blessing v. Freestone, 520 U.S. 329 (1997) 20

Bullfrog Films, Inc. v. Wick, 847 F.2d 502 (9th Cir. 1988) 9

California Gillnetters Assn. v. Department of Fish & Game, 39 Cal.App.4th 1145, 46 Cal.Rptr.2d 338 (1995) 12

Carroll v. *Safford*, 44 U.S. 441, 3 How. 441 (1845) 19

Clark v. City of Lakewood, 259 F.3d 996 (9th Cir. 2001) 8-9

Cooley v. Superior Court 29 Cal.4th 228, 127 Cal.Rptr.2d 177, 57 P.3d 654 (2002) 11

Coons v. Lew, No. 13-15324, 2014 U.S. App. LEXIS 17360 (9th Cir. Sep. 2, 2014) 9

Crawford v. Marion Cty. Election Bd., 553 U.S. 181 (2008) 8

Cunningham v. Superior Court, 177 Cal.App.3d 336, 222 Cal. Rptr. 854 (1986) 11, 12

Davis v. *Gray*, 83 U.S. 203, 16 Wall. 203 (1873) 19

DeMando v. Morris, 206 F.3d 1300 (9th Cir. 2000) 9

Ex Parte Young, 209 U.S. 123 (1908) 19

FEC v. Akins, 524 U.S. 11 (1998) 9

Foti v. City of Menlo Park, 146 F.3d 629 (9th Cir. 1998) 7

Guar. Nat'l Ins. Co. v. Gates, 916 F.2d 508 (9th Cir. 1990) 12

Haw. Hous. Auth. v. Midkiff, 467 U.S. 229 (1984) 12

Horne v. Dep't of Agric., 135 S. Ct. 2419 (2015) 13

Hughes v. Talen Energy Mktg., 136 S. Ct. 1288 (2016) 15

In re De Laurentiis Entm't Grp. Inc., 963 F.2d 1269 (9th Cir. 1992) 12

Int'l Union v. Brock, 477 U.S. 274 (1986) 10

Managed Pharmacy Care v. Sebelius, 716 F.3d 1235 (9th Cir. 2013) 19

Nat'l Council of La Raza v. Cegavske, 800 F.3d 1032 (9th Cir. 2015) 10

Osborn v. *Bank of United States,* 22 U.S. 738, 9 Wheat. 738 (1824) 19

Preminger v. Principi, 422 F.3d 815 (9th Cir. 2005) 7

Schmier v. U.S. Court of Appeals for Ninth Circuit, 279 F.3d 817 (9th Cir. 2002) 10

Sierra Med. Servs. All. v. Kent, 883 F.3d 1216 (9th Cir. 2018) 13, 14, 20

Small Prop. Owners of San Francisco v. City & Cty. of San Francisco, 141 Cal. App. 4th 1388, 47 Cal. Rptr. 3d 121 (2006) 14

United States v. Kafka, 222 F.3d 1129 (9th Cir. 2000) 7, 8

United States v. Salerno, 481 U.S. 739 (1987) 8

WildEarth Guardians v. United States Dep't of Agric., 795 F.3d 1148 (9th Cir. 2015) 9, 10

CONSTITUTION

United States Constitution
Amend. V 5
Amend. XIV 5

FEDERAL STATUTES AND REGULATIONS

United States Code, Title 42
§ 1395a (§4507 of the Balanced Budget Amendment of 1997) 6, 14, 15, 19
§ 1983 2

42 CFR § 405.405, *et seq.* 14, 19

STATE STATUTES

California Health and Safety Code
§ 1371.31 (AB 72 § 2(a)) 4
§ 1371.9 (AB 72 § 3(a)) 4, 7

OTHER AUTHORITIES

Jaffe & Henderson, *Judicial Review and the Rule of Law: Historical Origins*,
72 L. Q. Rev. 345 (1956) 19

INTERNET

https://www.debt.org/medical/hospital-surgery-costs/ 15

https://www.gomedigap.com/blog/medicare-supplement-trends/ 17

https://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html 17

www.calhealthplans.org/pdfs/FactSheetRegulators-09-2015.pdf 17

Plaintiffs Association of American Physicians & Surgeons, Inc. ("AAPS") and Eileen Natuzzi, M.D. ("Dr. Natuzzi" and collectively, "Plaintiffs") hereby file their Memorandum of Points and Authorities in Opposition to the Motion to Dismiss by Defendant Shelley Rouillard ("Defendant"). [D.E. 34] Plaintiffs have no objection to the Request for Judicial Notice in Support of Motion Dismiss by Defendant. [D.E. 34-2]

Introduction

This is a challenge to California Assembly Bill 72 ("AB 72" or the "Act"). Plaintiffs' Amended Complaint bolsters standing by adding a plaintiff (Dr. Eileen Natuzzi) who has been injured by AB 72. Plaintiffs also add allegations about the application of AB 72 which converts this case from a mere "facial" challenge to an "as applied" one. The constitutional violations by AB 72 as applied include financial losses to Plaintiff Dr. Eileen Natuzzi and members of AAPS, as well as a loss in federal statutory rights by members of AAPS.

In support of its motion to dismiss, Defendant portrays AB 72 sympathetically as a law to end "surprise medical bills" which patients may occasionally receive in connection with medical procedures. (Def. Mem. 1, 4, 5, 7) But the provisions challenged here do not relate to surprise medical bills to patients. Instead, at issue here is how the application of AB 72 gives an unfair advantage to third-party payers, including health plans, and allows them to avoid their obligations to physicians. Specifically, AB 72 authorizes health plans to refuse to pay in full on the invoices by out-of-network physicians for services they perform.

If the elimination of "surprise medical bills" were the primary goal of AB 72, then it would have simply required transparency in pricing or informed billing consent, without authorizing health plans to reduce their payments to out-of-network physicians to only 125% of Medicare and without subjecting physicians to a cost-prohibitive mandatory dispute resolution procedure. AB 72 does not even apply to emergency services or uninsured patients, which would comprise the bulk of "surprise medical bills."

Instead, AB 72 targets billing by out-of-network physicians of health plans, giving an unfair and unconstitutional advantage to those payers.

In addition, AB 72 is contrary to federal law, and preempted by it, concerning the rights of physicians who have opted out of or disenrolled from Medicare ("Opted-Out Physicians"). Opted-Out Physicians are allowed under federal law to agree to private contracts with patients for payment of services, pursuant to federal regulations. But AB 72 imposes a different, more burdensome set of requirements for entering into a private contract with patients for services provided. Defendant should be enjoined against the application of AB 72 in violation of federal law.

Statement of Facts

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 imposes a mandatory dispute resolution process that is cost-prohibitive for many physicians, thereby depriving them of their procedural rights to challenge underpayments in a feasible manner. (*Id.* ¶ 2) The implementation of AB 72 has resulted in substantial losses to physicians, including Plaintiff Dr. Natuzzi and members of Plaintiff AAPS. (*Id.*) As applied, AB 72 has caused a sharp, unreasonable decline of 25% in payments to physicians who are noncontracting ("out-of-network") with health care service plans ("health plans"). (*Id.* ¶ 3) These payments are in some cases below the true economic costs and investment-backed expectations, and are thereby confiscatory. (*Id.*)

AB 72 as applied is causing ongoing harm to out-of-network and opted-out AAPS members who practice in California, and to Plaintiff Dr. Natuzzi. (*Id.* ¶ 5) Plaintiffs seek declaratory and injunctive relief under 42 U.S.C. § 1983 and the equitable powers of this Court to enjoin these continuing violations of the U.S. Constitution. (*Id.* ¶ 6)

Plaintiff AAPS is a not-for-profit membership organization incorporated under

the laws of Indiana and headquartered in Tucson, Arizona. (*Id.* ¶ 7) Founded in 1943, AAPS has members in virtually every specialty; many AAPS members are out-of-network with health plans, and many have opted out of or are disenrolled from Medicare. (*Id.*) These members of AAPS in California are harmed by the violations of the U.S. Constitution by AB 72. (*Id.*) Moreover, the protection of AAPS members from unconstitutional action is central to AAPS's mission on behalf of its members. (*Id.*)

Plaintiff Eileen Natuzzi, M.D. ("Dr. Natuzzi") is a resident of California, and is a surgeon practicing in Encinitas, California. (*Id.* ¶ 8) Defendant Shelley Rouillard ("Defendant") is a defendant in her official capacity as the Director of the California Department of Managed Health Care ("DMHC"). (*Id.* ¶ 9) DMHC is the agency authorized and responsible to execute the laws of California relating to health care service plans under the Knox-Keene Health Care Service Plan Act of 1975. (*Id.*) Defendant Rouillard is the executive authorized to oversee the regulation of health plans in California, and to implement AB 72 with respect to health plans. (*Id.*)

Plaintiff Dr. Natuzzi's standing is based on losses she has already suffered due to the implementation of AB 72, in the form of a loss of 25% of her revenue in 2018 due to reduced reimbursements by health plans, and these injuries are ongoing and continuous. (*Id.* ¶ 14) Members of Plaintiff AAPS have similar standing, and Plaintiff AAPS has associational standing on behalf of its members. (*Id.* ¶¶ 13, 15, 29)

In addition, Opted-Out Physicians have a federal right to enter into private contracts with Medicare-enrolled patients for private payment for services rendered. (*Id.* ¶ 13) But AB 72 prohibits Opted-Out Physicians from receiving private payments from Medicare-enrolled patients for services provided at in-network facilities, unless the

different and more burdensome consent requirements of AB 72 are satisfied. (*Id.*) Many patients are older than 65 and thus are Medicare-enrolled, and AB 72 is causing losses to Opted-Out Physicians by infringing on their federal right to enter into privately agreed rates. (*Id.*) Plaintiff AAPS has associational standing based on its members who are Opted-Out Physicians. (*Id.* ¶¶ 13, 15)

Effective beginning July 1, 2017, AB 72 has reduced reimbursements to out-of-network (noncontracting) physicians to the greater of the average in-network rate or 125% of Medicare. *See* The Act § 2(a) (adding Section 1371.31 to the Health and Safety Code). (*Id.* ¶ 16) AB 72 prohibits an out-of-network physician from recovering fully on his or her claims for services lawfully rendered. (*Id.* ¶ 17) Specifically, AB 72 requires physicians to refund payments received above the in-network amount. *See* The Act § 3(a)(4)(A) (adding Section 1371.9 to the Health and Safety Code). (*Id.*) AB 72, as applied, thereby limits physicians to receiving merely whatever amounts the health plans choose to pay. (*Id.* ¶ 18) In addition, the implementation of AB 72 since September 1, 2017, has required that out-of-network physicians must participate in the Non Emergency Services Independent Dispute Resolution Process ("AB 72 IDRP") for any disputes on payments to them, rather than pursue their remedies directly in court. (*Id.* ¶ 19) The AB 72 IDRP requires that physicians first engage in a time-consuming internal process with the health plans before even reaching the arbitration-like process, which then charges a minimum of $315 as a fee even though the amount in dispute may be less than that. (*Id.*)

Defendant's implementation of AB 72 has caused health plans to decrease payments by an unreasonable 25% to out-of-network physicians, including Plaintiff Dr. Natuzzi. (*Id.* ¶ 20) This abrupt, unreasonable reduction by 25% in payments to out-of-

network physicians under AB 72, without any feasible legal recourse for physicians due to the mandatory AB 72 IDRP procedures imposed by the implementation of the Act, has caused a decrease in the availability of timely medical services to patients. (*Id.* ¶ 21)

The mandatory AB 72 IDRP procedures for physicians who are underpaid by health plans violate the Due Process Clause of the U.S. CONST., Amend. XIV (the "Due Process Clause") by creating a cost-prohibitive impediment to challenging underpayments. (¶ 23) Specifically, the implementation of AB 72 requires that physicians first participate in a cumbersome, futile internal review process with the health plan, and then pay a dispute-resolution fee with the AB 72 IDRP which is often larger than the amount in dispute. (*Id.* ¶ 24) By imposing this unfeasible procedure, Defendant's implementation of AB 72 renders the process too expensive and too time-consuming for Plaintiff Dr. Natuzzi and AAPS members to contest underpayments by health plans on individual claims. (*Id.*) Plaintiffs seek a declaratory judgment that AB 72, as applied, constitutes a violation of the Due Process Clause with respect to its imposition of an impractical procedure for challenging underpayments. (*Id.* ¶ 25)

Out-of-network members of AAPS and Plaintiff Dr. Natuzzi have seen an abrupt, unreasonable decrease of roughly 25% in their reimbursements by health plans based on the implementation of AB 72. (*Id.* ¶ 29) This unreasonable decline of 25% in payments to out-of-network members of AAPS and Plaintiff Dr. Natuzzi is contrary to their investment-backed expectations for their medical practices, which include the immense time and money spent on their training and current office expenses. (*Id.* ¶ 30) This sudden decrease in payments due to AB 72 is a violation of the Takings Clause of the Fifth Amendment of the U.S. Constitution ("Takings Clause"). (*Id.* ¶ 31)

In addition, the implementation of AB 72 has rendered it economically unfeasible for out-of-network AAPS members to take as much on-call in connection with the Emergency Room, as the implementation of AB 72 has decreased reimbursements for some of these services below their true economic costs, and thus the reduced reimbursements are thereby confiscatory. (*Id.* ¶ 32)

The application of AB 72 also violates federal law, namely Section 4507 of the Balanced Budget Act of 1997 (42 U.S.C. § 1395a), which authorizes Opted-Out Physicians to enter into private contracts with patients who are Medicare beneficiaries to obtain agreed-upon fees for services rendered. (Am. Compl. ¶ 37) AB 72 prohibits Opted-Out Physicians from collecting anything for their services rendered to Medicare beneficiaries, other than perhaps a small co-pay or payments based on agreements that comply with the onerous requirements of Section 3(c) of the Act. (*Id.* ¶ 39) The vast majority of patients over 65 years old are Medicare beneficiaries, and yet the application of AB 72 denies the Opted-Out Physicians fair compensation for their services to these patients. (*Id.*) AB 72 requires that:

> (1) Except [when there is coverage for out-of-network services] … a health care service plan contract issued, amended, or renewed on or after July 1, 2017, shall provide that if 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. This amount shall be referred to as the "in-network cost-sharing amount."
>
> (2) An enrollee shall not owe the noncontracting individual health professional more than the in-network cost-sharing amount for services subject to this section. …

> (3) A noncontracting individual health professional 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) (adding Section 1371.9 to the Health and Safety Code). (*Id.* ¶ 40)

Application of the foregoing requirements of AB 72 violate federal law by interfering with the ability of Opted-Out Physicians to receive payment for services rendered at hospitals that participate in Medicare, as virtually all hospitals do. (*Id.* ¶¶ 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)

Legal Standard

Other than the issue of "facial" versus "as applied" challenges, Plaintiffs adopt Defendant's Standard of Review (Def. Mem. 6-7). But Plaintiffs dispute Defendant's claim that this is merely a "facial" challenge to AB 72. Plaintiffs' lawsuit is primarily an "as applied" challenge at this point, roughly a year after AB 72 went into effect. Plaintiffs' request for broad relief is customary and does not convert this "as applied" challenge into merely a "facial" challenge. *See Preminger v. Principi*, 422 F.3d 815, 822 (9th Cir. 2005) ("[P]laintiffs have available judicial avenues in which to bring ***both as-applied and facial*** challenges to VA regulations.") (emphasis added).

The Amended Complaint was filed nearly a year after AB 72 went into effect, and alleges damages caused by AB 72 to Plaintiff Dr. Natuzzi and to members of Plaintiff AAPS. Plaintiffs also challenge the implementation of procedures under AB 72, which further renders this to be an "as applied" challenge, not a "facial" challenge.

"'[A]n as-applied challenge contends that the law is unconstitutional as applied to the litigant's particular [activities], even though the law may be capable of valid application to others.'" *United States v. Kafka*, 222 F.3d 1129, 1130 n.1 (9th Cir. 2000) (quoting *Foti v. City of Menlo Park*, 146 F.3d 629, 635 (9th Cir. 1998)). Plaintiffs do not contend that there is no possible constitutional application of AB 72, which is the

demanding standard that must be met under a facial challenge to a statute. *See Kafka*, 222 F.3d at 1130 n.1 ("'[a] facial challenge to a legislative Act is, of course, the most difficult challenge to mount successfully, since the challenger must establish that no set of circumstances exists under which the Act would be valid'") (quoting *United States v. Salerno*, 481 U.S. 739, 745 (1987)). The implementation and effects of AB 72 are properly alleged, and Plaintiffs need satisfy only the standard for as-applied challenges.

Argument

I. Plaintiffs, Who Include Members of an Association and an Individual Physician Who Has Been Injured by AB 72, Have Standing.

Despite Plaintiffs' addition of an individual as a Plaintiff (Dr. Eileen Natuzzi), Defendant nevertheless challenges Plaintiffs' standing. (Def. Mem. 11-14) But associational standing is properly alleged for Plaintiff AAPS, and individual standing is properly alleged for Plaintiff Dr. Natuzzi. It is well-established that standing by merely one plaintiff is sufficient to create standing for all plaintiffs. *See Crawford v. Marion Cty. Election Bd.*, 553 U.S. 181, 189 n.7 (2008) ("We also agree with the unanimous view of those judges that the Democrats have standing to challenge the validity of SEA 483 and that there is no need to decide whether the other petitioners also have standing.").

The addition of Plaintiff Eileen Natuzzi, M.D., to this case resolves any issues about standing. She has been severely harmed by the application of AB 72, by suffering a 25% decrease in her income:

> Plaintiff Dr. Natuzzi has standing based on losses she has already suffered due to the implementation of AB 72, in the form of a loss of 25% of her revenue in 2018 due to reduced reimbursements by health plans. These injuries to Plaintiff Dr. Natuzzi are ongoing and continuous.

(Am. Compl. ¶ 14) Such a loss suffices to satisfy the requirements of standing. An "economic loss suffered as a result of an adult zoning ordinance is a cognizable injury and is sufficient to satisfy the Article III standing requirement." *Clark v. City of*

Lakewood, 259 F.3d 996, 1007 (9th Cir. 2001) (citation omitted). Here, there is an economic loss due to application of AB 72, and thus standing clearly exists. "[W]e hold that plaintiffs-appellees clearly have standing to sue. They allege adequate injuries in fact in the form of pecuniary losses and deprivation of the opportunity to compete for valuable treaty-benefits." *Bullfrog Films, Inc. v. Wick*, 847 F.2d 502, 514 (9th Cir. 1988). This is not merely "speculative alleged injuries" that would fail to satisfy standing. *See, e.g.*, *Coons v. Lew*, No. 13-15324, 2014 U.S. App. LEXIS 17360, at *13 (9th Cir. Sep. 2, 2014). Rather, the losses to Plaintiff Natuzzi have already occurred, so she has standing.

In addition, Plaintiff AAPS has associational standing based on members who, like Plaintiff Dr. Natuzzi, have also already suffered substantial losses in reimbursements due to the application of AB 72. (Am. Compl. ¶¶ 29-30) The Opted-Out Physicians who are members of Plaintiff AAPS also have standing because they have immediately lost rights due to the implementation of AB 72. (*Id.* ¶ 13) A mere loss of a right is sufficient "injury in fact for purposes of Article III standing." *DeMando v. Morris*, 206 F.3d 1300, 1303 (9th Cir. 2000) (citing *FEC v. Akins*, 524 U.S. 11 (1998)). *See also 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 finding standing for an environmental group based on allegations about harm to the environment).

The losses by Plaintiff Dr. Natuzzi and members of Plaintiff AAPS are real and have already occurred, so there is nothing speculative about them. AB 72 has been in effective for more than a year, since July 1, 2017. Defendant raises a factual argument as to whether the losses are caused by AB 72. (Def. Mem. 1 n.2) But the Amended Complaint alleges that these losses of 25% in reimbursements are caused by AB 72,

which is all that is necessary at the pleading stage. "The implementation of AB 72 … caus[es] a sharp, unreasonable decline of 25% in payments to out-of-network physicians for services rendered, which is below their true economic costs and investment-backed expectations with respect to some of their medical services." (Am. Compl. ¶ 3)

For purposes of standing, Plaintiffs need not show "unsuccessful appeals pursuant to the Act's IDRP" or prove the "inability to seek reasonable rates of reimbursement in state court," as Defendant insists. (Def. Mem. 12) Plaintiff Dr. Natuzzi and members of Plaintiff AAPS have already suffered actual losses in revenue due to implementation of AB 72. That allegation suffices to establish standing at the pleading stage.

Plaintiffs do not allege mere hypothetical, future harm, but rather Plaintiffs allege that harm has already occurred. Thus the precedent upon which Defendant relies, *Schmier v. U.S. Court of Appeals for Ninth Circuit,* 279 F.3d 817, 821 (9th Cir. 2002), is inapplicable, because the plaintiff could not point to any financial or otherwise legally cognizable harm arising from a challenged rule. *Id.* at 820-21. Here, Plaintiffs have.

Plaintiff AAPS also fully satisfies "the concrete injury-in-fact, causation, and redressability requirements for standing." *WildEarth Guardians*, 795 F.3d at 1155. The Ninth Circuit does not impose an overly demanding requirement of associational standing as sought by Defendant. *See Nat'l Council of La Raza v. Cegavske*, 800 F.3d 1032, 1041 (9th Cir. 2015) (no need to identify members injured in order to establish associational standing); *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").

II. Plaintiffs State a Valid Due Process Claim, as *Bell v. Blue Cross* Establishes that It Violates the Constitution to Prohibit Out-of-Network Compensation at Out-of-Network Rates.

The mandatory AB 72 IDRP procedure for physicians violates the Due Process

Clause by creating a cost-prohibitive impediment to challenging underpayments. (Am. Compl. ¶ 23) The implementation of AB 72 requires that physicians first participate in a cumbersome, futile internal review process with the health plan, and then be subjected to the AB 72 IDRP dispute resolution process which often costs more than the amount in dispute. (*Id.* ¶ 24) By imposing this unfeasible procedure, Defendant's implementation of AB 72 renders the process too expensive and time-consuming for Plaintiff Dr. Natuzzi and AAPS members to contest underpayments by health plans on individual claims. (*Id.*) "The AB 72 IDRP requires that physicians first engage in a time-consuming internal process with the health plans before even reaching the arbitration-like process, which then charges a minimum of $315 as a fee even though the amount in dispute may be less than that." (Am. Compl. ¶ 19)

It is well-established that "a professional cannot be forced to give away a portion of his livelihood." *Bell v. Blue Cross of Cal.*, 131 Cal. App. 4th 211, 220, 31 Cal. Rptr. 3d 688, 695 (2005) (citing *Cunningham v. Superior Court*, 177 Cal.App.3d 336, 348, 222 Cal. Rptr. 854, 862 (1986)). "An attorney who is appointed to represent an indigent without compensation is effectively forced to give away a portion of his property – his livelihood." *Cunningham*, 177 Cal. App. 3d at 348, 222 Cal. Rptr. at 862. "Other professionals, merchants, artisans, and state licensees, are not similarly required to donate services and goods to the poor." *Id.*

Defendant's own authority explains that it is unconstitutional to compel physicians to accept underpayments for the services they render:

> Blue Cross's interpretation would mean the emergency care providers could be reimbursed at a confiscatory rate that, aside from being unconscionable, ***would be unconstitutional***. (*Cooley v. Superior Court* (2002) 29 Cal.4th 228, 252 [127 Cal.Rptr.2d 177, 57 P.3d 654] [a statute should be interpreted to avoid

> constitutional difficulties]; *Cunningham v. Superior Court* (1986) 177 Cal.App.3d 336, 348 [222 Cal.Rptr. 854] [a professional cannot be forced to give away a portion of his livelihood]; *California Gillnetters Assn. v. Department of Fish & Game* (1995) 39 Cal.App.4th 1145, 1156 [46 Cal.Rptr.2d 338].)

Bell v. Blue Cross of Cal., 131 Cal. App. 4th 211, 220, 31 Cal. Rptr. 3d 688, 695 (2005) (emphasis added).

By imposing a cost-prohibitive impediment to physicians for challenging underpayments on their services, the mandatory AB 72 IDRP procedure violates the Due Process Clause. Analogous mandatory arbitration provisions have been stricken by courts. *See, e.g.*, *Haw. Hous. Auth. v. Midkiff*, 467 U.S. 229, 235 n.3 (1984) ("The District Court declared both the compulsory arbitration provision and the compensation formulae unconstitutional."). Moreover, insurance companies themselves have successfully challenged similar piecemeal, time-consuming arbitration burdens 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).

III. Plaintiffs State a Valid Takings Claim.

Defendant errs in arguing against Plaintiffs' takings claim by saying that "California law provides a plaintiff with a right to bring a claim in state court for the reasonable value of services rendered – quantum meruit." (Def. Mem. 19) That is true only for emergency services, as the authority cited by Defendant explains. *See Bell*, 131 Cal.App.4th at 216-217 (cited by Def. Mem. 19)[1] Emergency services are not the focus here.

[1] Defendant also relies on *In re De Laurentiis Entm't Grp. Inc.*, 963 F.2d 1269, 1272 (9th Cir. 1992), a decision concerning quantum meruit and a right to set-off in a bankruptcy case not involving health care. That precedent does not stand against Plaintiffs' claims here.

The unconstitutionality of AB 72 is in its application to non-emergency services. The State has improperly taken a constitutional right away from Plaintiffs for non-emergency services, by denying Plaintiffs their right to quantum meruit for those services and instead subjecting them to a cost-prohibitive dispute resolution scheme. That denial of compensation constitutes a violation of the Takings Clause.

Plaintiff Dr. Natuzzi has suffered substantial losses, roughly 25% of her revenue, due to application of AB 72. If she were a landlord who suffered such losses due to rent control, then she would clearly have a valid cause of action for a takings. *See, e.g.*, *Action Apartment Ass'n v. Santa Monica Rent Control Bd.*, 94 Cal. App. 4th 587, 606, 114 Cal. Rptr. 2d 412, 426 (2001). That precedent held that allegations concerning a Santa Monica ordinance requiring landlords to pay a mere three (3) percent on the security deposits by tenants was a valid takings claim. The result should not be any different for a professional who suffers a more substantial loss in compensation for her services. She has a valid cause of action for the taking of compensation for her services.

The Ninth Circuit recently recognized that there is a valid cause of action on an analogous takings claim by ambulance companies in challenging another law that limited their reimbursements:

> Although real property is the traditional realm of takings law, the Fifth Amendment also protects against the taking of personal property without just compensation. *Horne v. Dep't of Agric.*, 135 S. Ct. 2419, 2426, 192 L. Ed. 2d 388 (2015) ("Nothing in the text or history of the Takings Clause, or our precedents, suggests that the rule is any different when it comes to appropriation of personal property."). And voluntary participation in a market that is subject to regulation does not defeat a takings claim. *See id.* at 2430-31 (holding that raisin farmers' voluntary decision to participate in the raisin market did not defeat their takings claim against the Department of Agriculture's raisin-reserve requirement). Accordingly, § 1317(d) has the potential to effect a regulatory taking even though the Plaintiffs could avoid the regulation by simply ceasing to operate as ambulance companies.

Sierra Med. Servs. All. v. Kent, 883 F.3d 1216, 1225 (9th Cir. 2018).

In *Sierra Med. Servs.*, the ambulance companies stated a valid cause of action, and their lawsuit was not dismissed until ***after discovery***, on summary judgment. *See id.* at 1220 ("After discovery, [the Defendant agency] moved for summary judgment, which the district court granted on all counts."). Under this precedent, Defendant's motion to dismiss here should not be granted without further development of a factual record. If, after discovery, there is not evidence supporting a takings claim, only then should it be dismissed as it was in *Sierra Med. Servs.*

In sum, AB 72 infringes on the Takings Clause by compelling the transfer of property – the fair market value for compensation for services rendered – from out-of-network physicians to health plans that would otherwise be required to pay in full for the services rendered by the physicians. "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 S.F. v. City & Cty. of S.F.,* 141 Cal. App. 4th 1388, 1396-97, 47 Cal. Rptr. 3d 121 (2006).

IV. Plaintiffs State a Valid Cause of Action to Enjoin Defendant from Violating Federal Law concerning Contracts with Medicare Patients.

Federal law and regulations establish that physicians are allowed to opt out of Medicare and then contract privately with patients pursuant to federal regulations, without any restriction on the physician's subsequent billing of health plans, insurance policies, or patients. Defendant does not dispute this. (Def. Mem. 19) Section 1802 of the Social Security Act, as amended by § 4507 of the Balanced Budget Amendment of 1997, 42 U.S.C. § 1395a, fully authorizes this private billing. *See also* 42 CFR § 405.405. Under federal law, Medicare-eligible patients are entirely free to enter into agreements with physicians for treatment without constraint as to the fees:

> (a) Basic freedom of choice. Any individual entitled to insurance benefits under this title [the Medicare statute - 42 USCS §§ 1395 et seq.] may obtain health services from any institution, agency, or person qualified to participate under this

> title [42 USCS §§ 1395 et seq.] if such institution, agency, or person undertakes to provide him such services.

42 U.S.C.S. § 1395a(a).

This federal law fully preempts AB 72 for all individuals entitled to Medicare. "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, and Defendant should be enjoined from enforcing AB 72 with respect to any patients who are "entitled" to the Medicare program in any way, including patients in the Medigap program that is regulated by Defendant.

A. Federal Law Preempts AB 72 with respect to the Large Medicare Population.

While AB 72 specifically excludes Medi-Cal plans, which is Medicaid rather than Medicare, AB 72 does ***not*** exclude Medicare patients, who are a substantial percentage of all patients who receive medical care. (Am. Compl. ¶ 13) "Approximately 36 million patients per year are admitted to U.S. hospitals, and Medicare pays 90 percent of the costs for almost 42 percent of them."[2] So this is not a peripheral issue, but is central to the application of AB 72 against physicians with respect to their patient populations, which consist largely of Medicare patients.

Among the membership of Plaintiff AAPS in California are Opted-Out Physicians who have the federal right outlined above to enter into private contracts with Medicare-enrolled patients for private payment for services rendered. (Am. Compl. ¶ 13) But AB 72 prohibits these Opted-Out Physicians from billing privately, either the patients or their health plans, in connection with services provided to such Medicare-entitled patients at in-network facilities, unless the burdensome requirements of AB 72 are satisfied. (*Id.*)

[2] https://www.debt.org/medical/hospital-surgery-costs/ (viewed 7/1/18)

Defendant asserts two arguments in merely a half-page for dismissal of Plaintiffs' cause of action based on this federal preemption. (Def. Mem. 19) First, Defendant argues that "the Act is not, and has never been, applied to Medicare plans. So Plaintiffs' allegation that the Act precludes recovery for services rendered to Medicare beneficiaries is inaccurate." (*Id.*, citing Def. Exhibit 1, p. 2). But AB 72 governs patients, not merely plans. The very same exhibit that Defendant relies on for its argument says this about AB 72:

> The law applies ***to people*** in health plans regulated by the Department of Managed Health Care or the California Department of Insurance.

(*Id.*, emphasis added) In other words, the law does not merely apply to health plans; it applies with respect to patients who are in certain health plans. That distinction is essential. AB 72 interferes with the ability of physicians and patients, who are in health plans regulated by Defendant, to negotiate fees among themselves even if the health plan is not paying. Stated another way, if a patient is in a health plan regulated by Defendant, then AB 72 expressly prohibits all private contracts by a physician with that patient for a medical service, unless the burdensome requirements of AB 72 are satisfied.

But Opted-Out Physicians are authorized by federal law to enter into private contracts with these patients without price controls, and without the regulation imposed by AB 72. The federal law applies broadly to all services provided to patients who are enrolled in Medicare, and thereby enables Opted-Out Physicians enter into federally approved private contracts for such patients even respect to plans regulated by Defendant, including Medigap plans as explained below. The federal preemption applies more broadly than to specific Medicare plans themselves; the federal preemption applies to

every patient enrolled in Medicare, and to every plan, Medicare or private, which may cover their medical services.

Many people age 65 years old and over have "Medigap," which is a Medicare supplemental insurance policy sold by private companies in order to reimburse medical expenses not paid by Medicare, including copayments, deductibles, and coinsurance.[3] As its name implies, a Medigap policy fills in the gaps and reimburses what Medicare fails to cover. Medicare pays its share of the medical bill, and then Medigap pays all or most of the remainder of the bill.

Some Medigap plans are regulated by Defendant, and thereby fall within the scope of AB 72. As explained by the California Association of Health Plans on its website, Defendant regulates "Some Medicare Supplement (Medigap) Plans."[4] Thus services by physicians to patients who have those Medigap plans are regulated by AB 72, in conflict with the federal Medicare law. Nothing in AB 72 – or in Defendant's memorandum or exhibits – mentions any exclusion of Medigap from the application of AB 72.

Medigap is popular:

> As of the end of 2015, nearly 1 in 4 Medicare beneficiaries receives supplemental Medigap coverage. This means, there are almost 12 million Medigap enrollees. That's a lot of people! This is a 22% increase from the number of enrollees in 2010. Each year, this growth percentage steadily climbs, from 2% in 2011 to 6% in 2015.

See goMedigap (emphasis omitted).[5] California has about 12% of the population of the Nation, and thus nearly 1.5 million patients in California are in Medigap plans.

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[3] https://www.medicare.gov/supplement-other-insurance/medigap/whats-medigap.html (viewed 7/4/18).
[4] www.calhealthplans.org/pdfs/FactSheetRegulators-09-2015.pdf (viewed 7/4/18).
[5] https://www.gomedigap.com/blog/medicare-supplement-trends/ (viewed 7/4/18).

Opted-Out Physicians have a federal right to enter into federally compliant private contracts with Medicare patients who are enrolled in Medigap plans. But AB 72 prohibits those same private contracts with patients who are enrolled in Medigap plans regulated by Defendant, and AB 72 thereby violates federal law. The enforcement of AB 72 by Defendant should therefore be enjoined.

Moreover, the factual complexity of this issue renders it unsuitable for Defendant's motion to dismiss prior to development of a factual record. In Plaintiffs' "as-applied" challenge here, it would be premature to dismiss their complaint without discovery on this issue of the application of AB 72 to Medicare beneficiaries who are governed by federal law. Plaintiffs have satisfied their burden to give proper notice of their claim, which is all that is required at the pleading stage, and Plaintiffs need not prove their case in their Amended Complaint.

B. Plaintiffs Have a Valid Cause of Action Regardless of whether the Supremacy Clause Creates an Independent Private Right.

Defendant argues that the Supremacy Clause of the U.S. Constitution (Art. VI, cl. 2), "does not provide Plaintiffs with a private right of action." (Def. Mem. 3) While superficially correct, that does not preclude the relief sought by Plaintiffs here to enjoin Defendant from violating federal law by enforcing AB 72. *See* Am. Compl. Prayer for Relief (ii) (seeking "injunctive relief blocking enforcement of AB 72"). The existence of a private right of action is not necessary to seek injunctive relief against violation by a state official of a federal law, which is what Plaintiffs seek here. As explained by the Supreme Court: "we have long held that federal courts may in some circumstances grant injunctive relief against state officers who are violating, or planning to violate, federal law." *Armstrong v. Exceptional Child Ctr., Inc.*, 135 S. Ct. 1378, 1384 (2015) (citing

Osborn v. *Bank of United States*, 22 U.S. 738, 9 Wheat. 738, 838-839, 844 (1824); *Ex parte Young*, 209 U.S. 123, 150-51 (1908), citing *Davis* v. *Gray*, 83 U.S. 203, 16 Wall. 203, 220 (1873)). "What our cases demonstrate is that, 'in a proper case, relief may be given in a court of equity ... to prevent an injurious act by a public officer.'" *Armstrong*, 135 S. Ct. at 1384 (quoting *Carroll* v. *Safford*, 44 U.S. 441, 3 How. 441, 463 (1845)).

The Supreme Court elaborated further that "[t]he ability to sue to enjoin unconstitutional actions by state and federal officers is the creation of courts of equity, and reflects a long history of judicial review of illegal executive action, tracing back to England." *Armstrong*, 135 S. Ct. at 1384 (citing Jaffe & Henderson, *Judicial Review and the Rule of Law: Historical Origins*, 72 L. Q. Rev. 345 (1956)). Moreover, the Ninth Circuit itself has expressly recognized an implied right of action for violations of the Supremacy Clause. "[A] plaintiff seeking injunctive relief under the Supremacy Clause on the basis of federal preemption need not assert a federally created 'right' … but need only satisfy traditional standing requirements." *Managed Pharmacy Care v. Sebelius*, 716 F.3d 1235, 1251 (9th Cir. 2013) (inner quotations omitted).

Those traditional standing requirements are satisfied here because the federal "opt out" statute and regulations, 42 U.S.C. § 1395a; 42 CFR § 405.405, *et seq*., give physicians, including members of Plaintiff AAPS, an enforceable and unambiguous right to enter into private contracts with Medicare patients for services rendered, without limitation to only 125% of Medicare rates and without satisfying the difficult, cumbersome consent requirements of AB 72. This suffices to satisfy the test for standing to challenge a Supremacy Clause violation. *See All. of Nonprofits for Ins., Risk Retention*

Grp. v. Kipper, 712 F.3d 1316, 1325 (9th Cir. 2013) (explaining *Blessing v. Freestone*, 520 U.S. 329, 340-41 (1997)).

While *Kipper* has arguably been abrogated by *Armstrong*, the latter makes clear as quoted above that one may still sue to enjoin the violation of federal law by state officials in the enforcement of state law. Defendant's citation to *Sierra Med. Servs. All. v. Kent*, 883 F.3d 1216, 1223 (9th Cir. 2018), is not to the contrary. In *Sierra*, unlike here, there was apparently no federal statute that preempted the challenged state law. The plaintiffs in *Sierra* dropped their Supremacy Clause claim such that it was not even properly before the court. Here, the application by Defendant of AB 72 to patients enrolled in Medigap directly conflicts with the rights of Opted-Out Physicians under federal law to serve those patients without the burdens and restrictions of AB 72.

Finally, 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) Accordingly, enforcement of AB 72 must be enjoined.

Conclusion

Defendant's motion to dismiss should be denied in its entirety.

Dated: July 12, 2018

Respectfully submitted,

/s/ Andrew L. Schlafly
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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 July 12, 2018, I electronically filed the accompanying Plaintiffs' Memorandum of Points and Authorities in Opposition to the Motion to Dismiss 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
Andrew L. Schlafly
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