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Supreme Court of California
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No. S271501

**IN THE SUPREME COURT
OF THE STATE OF CALIFORNIA**

LARRY QUISHENBERRY,

Plaintiff and Appellant,

v.

UNITED HEALTH CARE, INC., UNITED HEALTH GROUP, INC., UNITED HEALTH CARE - CALIFORNIA, UHC - CALIFORNIA, UNITED HEALTHCARE INSURANCE, INC., UNITED HEALTHCARE SERVICES, INC., HEALTHCARE PARTNERS AFFILIATES MEDICAL GROUP, AND HEALTHCARE PARTNERS MEDICAL GROUP,

Defendants and Respondents.

DEFENDANTS AND RESPONDENTS' ANSWER BRIEF

After a Decision by the Court of Appeal
Second Appellate District, Division Seven, Case No. B303451
Los Angeles County Superior Court Case No. BC631077
The Hon. Ralph Hofer, Judge Presiding

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INTRODUCTION

Few things done by the federal government today can match the importance and complexity of Medicare. The Medicare program delivers healthcare benefits to aged and disabled Americans—nearly a fifth of the whole population. Since the enactment of Medicare Part C in 1997, the federal government has contracted with private entities to provide Medicare Advantage plans as an alternative to the traditional Medicare program. This array of options lets enrollees choose the Medicare benefits plan that works best for them.

The administration of MA plans is a federal affair from start to finish. The Centers for Medicare and Medicaid Services approve every MA plan on an annual basis. By federal statute, MA plans must cover the benefits in Medicare Parts A and B. And the federal government ensures that benefits are delivered with a high quality of care through a detailed regime under which CMS and MA plan administrators oversee healthcare providers. Should a dispute arise over Medicare coverage, federal law channels such disputes into three tiers of administrative review through CMS, with exclusive judicial review by a federal district court.

The preemption provision at issue here is another crucial plank undergirding the federal nature of MA plans. Congress commanded that "[t]he standards established under" Medicare Part C "shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with

respect to MA plans which are offered by MA organizations." (42 U.S.C. § 1395w-26(b)(3).)

Larry Quishenberry filed this action against Respondents because he believes that a doctor prematurely discharged his father from a skilled nursing facility despite a Medicare entitlement under his MA plan. He also asserts that Respondents were negligent in failing to intervene in the doctor's discharge decision as part of their duty to monitor their provider network. Quishenberry sues Respondents on theories of negligence, elder abuse, and wrongful death.

Federal standards govern each and every act challenged in the complaint, as the Court of Appeal recognized. To begin with, the complaint expressly relies on Medicare standards as the basis for all the claims because Respondents merely administered the MA plan and did not provide care to Eugene. These standards dictate whether skilled nursing care is a covered Medicare benefit, where to review a healthcare provider's determination that an enrollee is not eligible for a benefit, and how CMS and MA organizations engage in oversight of their contracted providers. Quishenberry's claims would ask a state jury to decide benefits questions reserved for CMS and would instruct entities regulated by CMS to intervene in provider decisions that are the province of federal law. Section 1395w-26(b)(3) upholds the federal nature of MA plans against these claims.

Quishenberry tries to avoid preemption by drawing distinctions nowhere to be found in the text, history, or purpose of the statute. He argues that the preemptive force of the statute

does not cover claims that merely duplicate federal requirements. But section 1395w-26(b)(3) does not distinguish among parallel state laws, supplementary state laws, and inconsistent state laws. Quishenberry also argues that the statute preempts only statutory claims that are directed at MA plans—not common-law claims or statutory claims of general applicability. But section 1395w-26(b)(3) does not distinguish between generally applicable laws and laws specifically aimed at MA plans. Nor does it distinguish between statutory claims and common-law claims. While the scope of preemption is narrowly cabined to the MA program, section 1395w-26(b)(3) simply does not turn on the form of the state law applied to an MA plan. The statute's plain text displaces *any* state law that addresses subjects already governed by federal standards for MA plans.

Adopting Quishenberry's stilted reading of section 1395w-26(b)(3) would undermine the federal scheme for MA plans. His reading also would create needless conflict with the Ninth Circuit and the Nevada Supreme Court, among the many other courts that agree with Respondents' understanding of settled principles of preemption and statutory interpretation. The only outlier appellate decisions are two thinly reasoned opinions from divisions of the California Court of Appeal that cabined the preemptive effect of the statute to positive enactments, excluding the common law. This Court can and should return unanimity to the interpretation of section 1395w-26(b)(3), as befits a statute designed to ensure national uniformity in the administration of MA plans.

If any of the claims avoid express preemption under section 1395w-26(b)(3), they run aground on principles of implied preemption under the Supremacy Clause. Several features of Quishenberry's claims independently compel this conclusion. Federal law controls the benefits offered by MA plans, and any attempt to enforce (let alone supplement) these benefits through state law would serve as an obstacle to uniform benefit administration. Quishenberry also targets the supposed incentives created by capitated payments, but he cannot assert state-law claims that frustrate Congress's decision to structure Medicare Part C in this manner. Finally, the discharge decision could have been reviewed through the four-tier system of exclusive review established for Medicare claims. Subsequent state-court litigation of Medicare issues would weaken the integrity of the federal procedures.

In short, Congress intended broad preemption of state-law claims with respect to MA plans—the very claims that Quishenberry alleges here. The Court of Appeal therefore got it right, and this Court should affirm.

BACKGROUND

I. Medicare Part C.

Since 1965, Medicare has provided health insurance to millions of Americans. And the program has only grown over the past half century in terms of beneficiaries and covered benefits. "Medicare stands as the largest federal program after Social Security," with annual expenditures of $700 billion to insure the health of "nearly 60 million aged or disabled Americans, nearly

one-fifth of the Nation's population." (*Azar v. Allina Health Services* (2019) 139 S.Ct. 1804, 1808.)

As originally enacted, Medicare contained only Part A and Part B. (See Social Security Amendments of 1965, Pub.L. No. 89-97, § 102 (July 30, 1965), 79 Stat. 286, 291–332, as amended, 42 U.S.C. § 1395 et seq.) Part A automatically insures aged and disabled individuals for inpatient treatment and other hospital services. (See §§ 1395c to 1395i-6.) Part B is a voluntary program that provides supplemental insurance coverage to Medicare enrollees for other medically necessary services and preventive services. (See §§ 1395j to 1395w-6.)

The same decade that Congress passed the Medicare Act, insurers and healthcare entities began to establish health maintenance organizations as an alternative to traditional fee-for-service medical care in the private healthcare market. (*Pegram v. Herdrich* (2000) 530 U.S. 211, 218–219.) The federal HMO Act of 1973 accelerated this trend by "encourag[ing] the development of HMOs." (*Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355, 367.) HMOs do not pay providers on a "fee-for-service" basis—that is, they do not pay a specific amount "for a general physical exam, a vaccination, a tonsillectomy, and so on." (*Pegram*, 530 U.S. at 218.) Instead, HMOs pay providers a "fixed fee for each patient enrolled" under the plan, and thus the providers assume the risk that the enrollee's actual healthcare costs will exceed the fee. (*Id.* at 218–219.) Notwithstanding some critics' view that this arrangement might place "financial self-interest" at odds with the physician's professional obligation

to provide medically appropriate services, “HMOs became popular because fee-for-service physicians were thought to be providing unnecessary or useless services.” (*Id.* at 220.)

Congress incorporated the HMO model into public healthcare law by enacting Medicare Part C in 1997. (Balanced Budget Act of 1997, Pub.L. No. 105-33, § 4001 (Aug. 5, 1997), 111 Stat. 251, 275–336, as amended, 42 U.S.C. §§ 1395w-21 to 1395w-28.) Part C established the Medicare+Choice program—now called Medicare Advantage or MA—as “an alternative to the traditional Part A fee-for-service system” under which the government makes payments directly to providers such as hospitals. (*Northeast Hosp. Corp. v. Sebelius* (D.C.Cir. 2011) 657 F.3d 1, 2.) Congress believed that Part C would “allow beneficiaries to have access to a wide array of private health plan choices” and “enable the Medicare program to utilize innovations that have helped the private market contain costs and expand health care delivery options.” (H.R.Conf.Rep. No. 105-217, 1st Sess., p. 585 (1997).)

Under Part C, the MA organization receives a capitated payment (a monthly fixed fee per enrollee) from the Centers for Medicare and Medicaid Services (CMS) in exchange for the MA organization stepping into the shoes of the federal government to provide Medicare benefits. (See *Roberts v. United Healthcare Services, Inc.* (2016) 2 Cal.App.5th 132, 140; *Matthews v. Leavitt* (2d Cir. 2006) 452 F.3d 145, 146, fn. 1.) CMS approves MA plans through a process of bidding and negotiation. (42 C.F.R. § 422.250 et seq.) MA plans must provide the benefits available

under Medicare Parts A and B (42 U.S.C. § 1395w-22(a)(1)) and may offer such supplemental benefits as are approved by the Secretary of Health and Human Services (§ 1395w-22(a)(3)). MA organizations can pay participating healthcare entities a capitated rate to provide these benefits. (See § 1395w-25(b)(4).)

Congress has established a comprehensive remedial regime to review the denial of Medicare benefits under MA plans. MA organizations must make procedures available for reviewing coverage determinations (42 C.F.R. § 422.566), and a dissatisfied enrollee can obtain administrative review (§§ 422.600, 422.608). Federal district courts have exclusive jurisdiction over the decisions of CMS ALJs and of the Medicare Appeals Council. (42 U.S.C. § 1395w-22(g)(5); 42 C.F.R. § 422.612.)

Given the importance of the federal function delegated to the MA organization, CMS has the authority to extensively regulate MA plans and MA organizations. (See 42 U.S.C. § 1395w-26(b)(1).) Congress has protected this regulatory authority since the inception of Medicare Part C with an express preemption provision. (See Balanced Budget Act of 1997, § 4001, 111 Stat. 319.) In 2003, Congress considerably broadened the scope of preemption, as explained further below in Argument Part I.C. The current preemption rule is that federal standards "shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations." (42 U.S.C. § 1395w-26(b)(3).)

II. The complaint.

After the death of his father, Larry Quishenberry filed this lawsuit. (1AA15.) This case now concerns the second amended complaint, which Quishenberry filed after the trial court sustained a demurrer to the first amended complaint on preemption and exhaustion grounds. (1UA64.) For simplicity's sake, this brief refers to the plaintiff as "Quishenberry" and his father as "Eugene."

Eugene enrolled in an MA plan offered by UnitedHealthcare. (1AA27 [SAC ¶ 5].) As the complaint alleges, this MA plan obligated UnitedHealthcare to provide "those health care benefits and administrative protections to which Eugene was due under Medicare." (1AA28 [SAC ¶ 6].) UnitedHealthcare contracted with Healthcare Partners Medical Group to administer Eugene's MA plan with respect to physician services. (1AA29 [SAC ¶ 10].)

In November 2014, Eugene, then 85 years old, began his stay at a skilled nursing facility, GEM Healthcare LLC, following his discharge from a hospital for a broken hip. (1AA30, 1AA32–33 [SAC ¶¶ 12, 21, 26].) GEM provided physical therapy and care for pressure sores that Eugene had developed on his feet. (1AA30 [SAC ¶ 12].) The care that Eugene received at GEM qualified as a Medicare benefit. (1AA30 [SAC ¶ 12].) Dr. Jae Lee was Eugene's treating physician during his stay. (1AA30 [SAC ¶ 11].) After Eugene had spent 24 days at GEM, Dr. Lee discharged Eugene to his home. (1AA33 [SAC ¶ 26].)

The complaint alleges that Dr. Lee and GEM did not properly treat Eugene's pressure sores. (1AA32 [SAC ¶ 23].) It further alleges that Eugene was entitled *under Medicare* to an additional 76 days of skilled nursing care at GEM. (1AA33 [SAC ¶ 26].) Eugene instead received in-home care until his death nine months later. (1AA33 [SAC ¶ 27]; see Opn. at 5, fn. 6.) According to the complaint, Eugene died as a result of his premature discharge from GEM. (1AA33 [SAC ¶ 27].)

Quishenberry brings several tort claims—negligence, elder abuse, negligence arising from a special relationship, and wrongful death—against UnitedHealthcare, Healthcare Partners, and Dr. Lee under state law as the successor to Eugene and as an heir. (1AA26 [SAC ¶ 2].) He also pleaded a claim of insurance bad faith but did not challenge its dismissal on appeal. (Opn. at 3, fn. 3.) Previously, he sued GEM—one of the two defendants who, along with Dr. Lee, provided care to Eugene—but GEM settled those claims before he filed his second amended complaint. (*Id.* at 4, fn.5.)

Each claim against UnitedHealthcare and Healthcare Partners arises from a common set of allegations, all premised on a purported failure to provide a benefit due under Medicare and a supposed failure to comply with standards set by Medicare:

- Respondents (the UnitedHealthcare and Healthcare Partners entities) were obligated "to provide, at a minimum, those health care benefits and administrative protections to which Eugene was due

under Medicare." (1AA28–29 [SAC ¶¶ 6, 9], italics added.)

- "Those health care benefits . . . included custodial care within skilled nursing facilities such as GEM." (1AA28 [SAC ¶ 7].)
- On Dr. Lee's orders, "and pursuant to the business practice of [Healthcare Partners] and [UnitedHealthcare], GEM furnished Eugene with a false statement that he was no longer qualified *under Medicare* for further inpatient care at GEM." (1AA33 [SAC ¶ 26], italics added.)
- Respondents knew "that GEM was not providing necessary skilled nursing care to its resident-patients" but "acquiesced to, encouraged, directed, aided and abetted Lee's action to discharge Eugene under circumstances where acceptable medical practice *and Medicare rules* required that Eugene remain at GEM for more intense attention to his health care needs." (1AA33 [SAC ¶ 29], italics added.)
- Respondents "were by contract *and by federal law* in a position to control the conduct of Lee and GEM in their provision of care to Eugene." (1AA35 [SAC ¶ 40], italics added.)
- "Instead of intervening to control GEM and Lee's treatment decision making, as by ensuring that GEM and Lee knew that further care and treatment at

GEM was a covered benefit *under Eugene's Medicare plan*," Respondents "failed to take any action, and allowed Lee and GEM's discharge [of] Eugene to home." (1AA41 [SAC ¶ 41], italics added.)

- Medicare's capitated payment scheme allegedly incentivized Respondents to provide less care to Eugene so that they could increase their profits. (1AA30 [SAC ¶ 13] ["Under this arrangement for a fixed monthly fee, as a general rule . . . the smaller the cost of care provided to enrollees, the more profit is realized from the said fixed monthly fee."].)

III. The trial court sustained Respondents' demurrers.

Respondents filed demurrers to the second amended complaint, which the trial court sustained on two grounds. First, the court held that the Medicare Act expressly preempts Quishenberry's claims against Respondents. (3AA671–672.) Second, the court held that Health & Safety Code section 1371.25 of the Knox-Keene Act independently prohibited the complaint's theory of vicarious liability against UnitedHealthcare. The trial court overruled, however, the demurrer filed by Dr. Lee, whose defenses are not before this Court on appeal. (3AA671.)

The trial court accordingly entered judgment in favor of UnitedHealthcare and Healthcare Partners. (3AA677–678, 3AA687.)

IV. The Court of Appeal affirmed the judgment.

The Court of Appeal affirmed the trial court's ruling based on both express and implied preemption.

The holding on express preemption centered on 42 U.S.C. § 1395w-26(b)(3). The Court of Appeal observed that Quishenberry's claims "are based on California law in an area in which Medicare Part C regulations have established standards for MA plans." (Opn. at 12.) Specifically, federal regulations set standards for covered benefits (including skilled nursing care), CMS approval of provider networks, and oversight of providers. (*Id.* at 12–14.) The Court of Appeal held that these standards preempted Quishenberry's state-law claims, which would require a determination whether Eugene was entitled to skilled nursing care under Medicare and whether Respondents engaged in sufficient oversight of GEM and Dr. Lee. (*Id.* at 15 & fn. 9.) This conclusion aligned with decisions by another division of the Second District (*Roberts*, 2 Cal.App.5th at 138, 143), the Ninth Circuit (*Do Sung Uhm v. Humana, Inc.* (9th Cir. 2010) 620 F.3d 1134, 1148–1153), and the Nevada Supreme Court (*Morrison v. Health Plan of Nev., Inc.* (Nev. 2014) 328 P.3d 1165, 1169). (See Opn. at 17–18.)

The Court of Appeal disagreed with Quishenberry's core argument that section 1395w-26(b)(3) preempts only positive state enactments that specifically target HMOs. On this point, the court held that the statute preempts generally applicable laws, including common-law duties, as applied to MA plans, in line with the analysis in *Roberts*. The Court of Appeal disagreed

with the decisions in *Cotton v. StarCare Medical Grp., Inc.* (2010) 183 Cal.App.4th 437 and *Yarick v. PacifiCare of Cal.* (2009) 179 Cal.App.4th 1158, which had held that the statute does not expressly preempt common-law duties. (Opn. at 20–23.) *Cotton* and *Yarick*, the Court of Appeal reasoned, had misapplied U.S. Supreme Court precedent on express preemption. (See *Roberts*, 2 Cal.App.5th at 145–147, discussing *Riegel v. Medtronic, Inc.* (2008) 552 U.S. 312 and *Sprietsma v. Mercury Marine* (2002) 537 U.S. 51.)

In the alternative, the Court of Appeal held that the Medicare Act impliedly preempts Quishenberry's claims as an obstacle to federal objectives. Review under state law of a premature discharge would "undermine CMS's ability to regulate Medicare benefits coverage, including eligibility requirements for skilled nursing facility care." (Opn. at 17, fn. 11, citing *Roberts*, 2 Cal.App.5th at 149; *Yarick*, 179 Cal.App.4th at 1167–1168.)

STANDARD OF REVIEW

The standard of review is de novo "because this case was resolved on a demurrer and because federal preemption presents a pure question of law." (*Farm Raised Salmon Cases* (2008) 42 Cal.4th 1077, 1089, fn. 10, citations omitted.) The de novo standard applies to both preemption issues on which this Court granted review. The interpretation of a statute, such as an express preemption provision, is an "issue of law." (*Union of Medical Marijuana Patients, Inc. v. City of San Diego* (2019) 7 Cal.5th 1171, 1183.) Obstacle preemption likewise presents a

legal question of congressional intent that is reviewed de novo. (*Quesada v. Herb Thyme Farms, Inc.* (2015) 62 Cal.4th 298, 308.)

ARGUMENT

Principles of express and implied preemption both lead to the same conclusion: The Medicare Act preempts the tort claims raised in the complaint.

The Supremacy Clause of the U.S. Constitution provides that federal law "shall be the supreme Law of the Land; and the Judges in every State shall be bound thereby, any Thing in the Constitution or Laws of any State to the Contrary notwithstanding." (Art. VI, cl. 2.) This Court has observed that the Supremacy Clause "establishes a constitutional choice-of-law rule, makes federal law paramount, and vests Congress with the power to preempt state law." (*Viva! Internat. Voice for Animals v. Adidas Promotional Retail Operations, Inc.* (2007) 41 Cal.4th 929, 935.)

Congress exercised its federal power to preempt state law in enacting 42 U.S.C. § 1395w-26(b)(3). This Court should hold that this provision expressly preempts Quishenberry's claims, each of which rests on state-law duties that are superseded by federal standards governing MA plans. But even if section 1395w-26(b)(3) does not preempt every claim, this Court should affirm the Court of Appeal's alternative holding that the claims stand as an obstacle to the system of federal standards, federal oversight, and federal review applicable to MA plans. Either ground would support an affirmance of the judgment below.

I. The Medicare Act expressly preempts the claims in this case.

Congress amended the Medicare Act in 2003 to expand the preemption of state law relating to Medicare Part C. The statute now provides: "The standards established under this part shall supersede any State law or regulation (other than State licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part." (42 U.S.C. § 1395w-26(b)(3).)

The question in this case is whether standards established under Part C "supersede" (or put another way, preempt) the state-law duties alleged in Quishenberry's complaint. The answer is "yes." Medicare sets forth standards for deciding whether skilled nursing care is a covered benefit, where to obtain review of a coverage decision, and how CMS and MA organizations monitor healthcare providers. Because those standards "supersede [the] State law[s]" that give rise to Quishenberry's claims, he cannot proceed with his allegations that Respondents' failure to properly monitor GEM and Dr. Lee deprived Eugene of a Medicare benefit.

None of Quishenberry's counterarguments alters this conclusion. He frames his entire argument around a presumption against preemption, but the U.S. Supreme Court has unequivocally rejected that presumption as a permissible tool for interpreting express preemption provisions like the one at issue here. He contends that section 1395w-26(b)(3) saves parallel state claims premised on federal standards, but the text

and history of that provision leave no doubt that federal standards supersede *any* state law as applied to MA plans (not just *inconsistent* state laws). Quishenberry also argues that generally applicable state laws escape preemption, but the phrase "with respect to" defines the degree to which federal law displaces state law—not the degree to which state law must single out MA plans for specific regulation. And pointing to two Court of Appeal decisions with scant reasoning (*Cotton* and *Yarick*), he strives to exclude common-law duties from preemption, but as other courts have explained, such a carveout cannot be reconciled with the text, context, and legislative objective to broadly preempt duplicative state regulation of MA plans.

A. Section 1395w-26(b)(3) preempts state laws that regulate the same subject matter as Medicare Part C standards.

The starting point for the interpretation of an express preemption provision is "the plain wording of the clause, which necessarily contains the best evidence of Congress' preemptive intent." (*Chamber of Commerce of United States of Am. v. Whiting* (2011) 563 U.S. 582, 594, quotation marks omitted.) When "the statute's language is plain," that "is also where the inquiry should end." (*Puerto Rico v. Franklin Cal. Tax-Free Tr.* (2016) 579 U.S. 115, 125, quotation marks omitted.) The words of the statute must be read in context—not as an archipelago of dictionary definitions—because "two words together may assume a more particular meaning than those words in isolation." (*FCC*

v. AT&T Inc. (2011) 562 U.S. 397, 406.) "Also relevant" to clear up any ambiguities are "the structure and purpose of the statute as a whole," including "the reviewing court's reasoned understanding of the way in which Congress intended the statute." (*People ex rel. Harris v. Pac Anchor Transp., Inc.* (2014) 59 Cal.4th 772, 778, quotation marks omitted.)

These traditional tools of statutory interpretation—text, context, structure, and purpose—all support the Court of Appeal's holding that section 1395w-26(b)(3) expressly preempts Quishenberry's claims.

1. The meaning of section 1395w-26(b)(3).

Section 1395w-26(b)(3) has four key textual components: "[1] The standards established under this part [2] shall supersede [3] any State law or regulation (other than State licensing laws or State laws relating to plan solvency) [4] with respect to MA plans which are offered by MA organizations under this part."

First, the *standards* that trigger the statute include, at a bare minimum, statutory provisions contained in Part C and regulations promulgated under Part C. (See *Uhm*, 620 F.3d at 1148, fn. 20.) The phrase "this part" refers to statutory provisions of Medicare Part C. And standards "established under this part" include CMS regulations promulgated pursuant to this authority. (See 42 U.S.C. § 1395w-26(b)(1).) CMS accordingly has enacted a parallel preemption regulation that clarifies that "standards established" for the MA program under Part 422 of Title 42 of the Code of Federal Regulations "supersede" state laws with respect to MA plans. (42 C.F.R. § 422.402.)

Second, these standards *supersede* state law. The ordinary meaning of "supersede" is "displace." (*Pharm. Care Mgmt. Assn. v. Wehbi* (8th Cir. 2021) 18 F.4th 956, 971; see *Boyle v. United Techs. Corp.* (1988) 487 U.S. 500, 507–508.) When a Part C statute or regulation addresses a subject, the federal standard displaces state law on that subject. (See *Morrison*, 328 P.3d at 1169.) But section 1395w-26(b)(3) leaves state law in place when no federal standard speaks to the conduct. (See *Pharm. Care Mgmt. Assn.*, 18 F.4th at 971.)

Third, the federal standards supersede *any state law or regulation*. As explained below, "any" means "any." (See post, at 45–46, 55.) The statute displaces state law whenever applied to a subject already governed by a federal standard. Congress then carved out *state licensing laws or state laws relating to plan solvency* (neither of which are at issue here). While States cannot regulate the administration of MA plans, they retain a gatekeeping function in determining which entities can offer such plans. (See, e.g., 42 C.F.R. § 422.400(a).)

Fourth, standards supersede state law *with respect to MA plans offered by MA organizations* under Medicare Part C. This language cabins the scope of preemption. As discussed later, section 1395w-26(b)(3) preempts state law only as applied to MA plans, not as applied to other plans offered by MA organizations. (See post, at 53.)

Putting those components in context, section 1395w-26(b)(3) has a sensible function: Part C standards "displace"

state laws "that regulate the same subject matter" as applied to MA plans. (*Pharm. Care Mgmt. Assn.*, 18 F.4th at 971.)

The structure of Medicare Part C and the purpose of section 1395w-26(b)(3) reinforce this plain meaning. For example, the conference report explains that "the MA program is a federal program operated under Federal rules" and that "[s]tate laws, do not, and should not apply" except with respect to licensing and solvency. (H.R.Conf.Rep. No. 108-391, 1st Sess., p. 557 (2003); see *T-Mobile South, LLC v. Roswell* (2015) 574 U.S. 293, 301 [conference report is evidence of legislative intent].)

Section 1395w-26(b)(3) is a "very broad" preemption provision. (*Morrison*, 328 P.3d at 1168.) The statute bears a resemblance to the preemption provision in the Employee Retirement Income Security Act, which this Court has recognized as the "classic example of clear congressional intent to preempt state remedies." (*McCall v. PacifiCare of Cal., Inc.* (2001) 25 Cal.4th 412, 422, citing 29 U.S.C. § 1144(a) [provisions of ERISA "shall *supersede* any and all State laws insofar as they may now or hereafter *relate to any employee benefit plan*"], italics added.) The phrase "with respect to" in section 1395w-26(b)(3) is "synonymous with the phrases 'with reference to,' '*relating to*,' 'in connection with,' and 'associated with.'" (*Huffington v. T.C. Grp., LLC* (1st Cir. 2011) 637 F.3d 18, 22, italics added.) Section 1395w-26(b)(3) and the ERISA preemption statute thus similarly "supersede" state law in connection with benefit plans. And the purpose of both statutes is to ensure uniform federal oversight and administration of these plans. (See *First Medical Health*

Plan, Inc. v. Vega-Ramos (1st Cir. 2007) 479 F.3d 46, 52 [Medicare Part C]; *Gobeille v. Liberty Mut. Ins. Co.* (2016) 577 U.S. 312, 320–321 [ERISA].) As Respondents explain below, precedent from the ERISA context provides additional confirmation that section 1395w-26(b)(3) preempts Quishenberry's claims.

2. The presumption against preemption does not apply to an express preemption provision.

Settled principles of statutory interpretation compel Respondents' reading of section 1395w-26(b)(3). In response, Quishenberry advances a "presumption against preemption" (OB-6) that is defunct in this context. There is no thumb on the scale against preemption because Congress has enacted a statute expressly speaking to the preemption of state law.

This Court previously recognized that the presumption's "continuing vitality" had "come into question," particularly in "cases interpreting express preemption clauses." (*Quesada*, 62 Cal.4th at 314.) Since *Quesada*, the U.S. Supreme Court has squarely held that, when "the statute contains an express pre-emption clause," courts "do not invoke any presumption against preemption but instead focus on the plain wording of the clause." (*Franklin*, 579 U.S. at 125, quotation marks omitted.) The presumption thus lost whatever remaining vitality it possessed with respect to express preemption.

Franklin forecloses Quishenberry's argument that "state laws are not to be expressly preempted unless that was the clear

and manifest purpose of Congress." (OB-6.) The "clear and manifest" standard first applied in *Rice v. Santa Fe Elevator Corp.* (1947) 331 U.S. 218 may retain some force for implied forms of preemption. (See *Solus Indus. Innovations, LLC v. Superior Court* (2018) 4 Cal.5th 316, 332.) But as courts have held in the wake of *Franklin*, the presumption against preemption plays no role in the interpretation of section 1395w-26(b)(3). (See *Pharm. Care Mgmt. Assn.*, 18 F.4th at 967; *Snyder v. Prompt Medical Transp., Inc.* (Ind.Ct.App. 2019) 131 N.E.3d 640, 652; see also *Thornton v. Tyson Foods, Inc.* (10th Cir. 2022) 28 F.4th 1016, 1023 [examples in other contexts].)

Nor does it matter that tort law arguably could be characterized as an exercise of a "traditional state power." (*Gobeille*, 577 U.S. at 325.) An express preemption clause overrides any presumption in favor of state law that might otherwise exist. (See, e.g., *Internat. Bhd. of Teamsters, Local 2785 v. Federal Motor Carrier Safety Admin.* (9th Cir. 2021) 986 F.3d 841, 853.) And the "particular label affixed" to the claims does not affect preemption, whether the State acts through tort law or legislation. (*Aetna Health Inc. v. Davila* (2004) 542 U.S. 200, 214; see *Riegel*, 552 U.S. at 325 ["[s]tate tort law" can "disrupt[] the federal scheme no less than state regulatory law to the same effect"].) While "general health care regulation" may be a traditional police power (*New York State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 661), the regulation of MA plans—like ERISA plans—surely

is not (see *Gobeille*, 577 U.S. at 325–326; see also H.R.Conf.Rep. No. 108-391, at 557).

In arguing for a presumption against preemption, Quishenberry invokes 42 U.S.C. § 1395. (OB-6.) Section 1395 provides, among other things, that the Medicare Act shall not "be construed to authorize any Federal officer or employee to exercise any supervision or control over the practice of medicine or the manner in which medical services are provided." But Respondents do not "practice . . . medicine"; they administer Medicare benefits on behalf of the federal government under standards set by the federal government. (See 42 U.S.C. §§ 1395w-26(b)(1), 1395w-27.) Section 1395 in no way affects the ability of CMS to regulate the Medicare program in this manner. (See *Biden v. Missouri* (2022) 142 S.Ct. 647, 654 [per curiam].) Accordingly, section 1395 does not curtail the scope of federal standards established for Medicare Part C—let alone the "specific substantive pre-emption provision" instructing that such standards supersede state law with respect to MA plans. (*Morales v. Trans World Airlines, Inc.* (1992) 504 U.S. 374, 385.)

Although this Court has interpreted section 1395 to "le[ave] open a wide field for the operation of state law pertaining to standards for the practice of medicine and the manner in which medical services are delivered to Medicare beneficiaries," that decision arose in an entirely different context—*implied* preemption. (*McCall*, 25 Cal.4th at 423–424.) There is no need to fall back on indirect inferences when (as here) a statute

confronts the question of preemption head on. (See *Franklin*, 579 U.S. at 125.)

B. Medicare Part C standards supersede the state-law duties alleged in the complaint.

Section 1395w-26(b)(3) preempts all of Quishenberry's claims. Federal standards regulate the benefits covered by MA plans, the review of coverage determinations about those benefits, and the process for monitoring provider performance. Because Quishenberry alleges that Eugene was entitled to skilled nursing care under his MA plan and that Respondents should have intervened to stop Dr. Lee's discharge order, Part C statutory provisions and regulations supersede his state-law claims.

1. Covered benefits.

The central premise of the complaint is that Respondents breached their duty to provide "those health care benefits and administrative protections to which Eugene was due under Medicare," including "custodial care within skilled nursing facilities." (1AA28 [SAC ¶¶ 6–7].) Quishenberry alleges that this benefit entitled Eugene to "another period of 76 days of care at GEM." (1AA33 [SAC ¶ 26].) And he further alleges that Respondents acquiesced to Dr. Lee's discharge of Eugene to in-home care. (1AA33 [SAC ¶ 29].) Medicare standards pervade every aspect of these allegations.

Specifically, federal law governs both what benefits MA organizations must offer in MA plans and how MA organizations must ensure access to those benefits. One rule is that MA plans

must cover the benefits that are covered under Parts A and B of Medicare. (42 U.S.C. § 1395w-22(a)(1); see 42 C.F.R. §§ 422.101(a), 422.504(a)(3).) To satisfy this coverage requirement, MA organizations must follow "CMS's national coverage determinations," "[g]eneral coverage guidelines included in original Medicare manuals and instructions," and "[w]ritten coverage decisions of local Medicare contractors." (§ 422.101(b).)

Quishenberry had previously argued that "the claim that [Eugene's] premature discharge was not medically appropriate" is "wholly apart from any standard established by the federal government." (PFR-19.) But that is plainly not true—the federal standards referenced throughout the complaint lay out specific prerequisites that dictate whether Medicare covers skilled nursing care and how long the stay will be, up to a maximum of 100 days. (42 U.S.C. § 1395d(a)(2)(A); 42 C.F.R. §§ 409.30–409.36.) As the complaint itself acknowledged, Medicare pegged Eugene's eligibility to "findings that he reasonably needed daily physical therapy" and that "his level of physical function" would improve or stabilize. (1AA32 [SAC ¶ 24].) And medical appropriateness does not alone determine eligibility under Medicare. Even if a service is medically appropriate under the federal standards, that does not mean that Medicare—and, by extension, the MA plan—covers the benefit. (See *Rapport v. Leavitt* (W.D.N.Y. 2008) 564 F.Supp.2d 186, 193–194.)

Quishenberry no longer tries to hide the fact that his state-law claims plead the "violation of federal standards concerning his [father's] right to remain in a skilled nursing facility

environment for 100 days to provide physical therapy." (OB-9.) That is the end of the line for his claims. If section 1395w-26(b)(3) means anything, it must mean that state law cannot regulate the MA plan's coverage of a benefit like skilled nursing care when Medicare sets forth its own standards for coverage. (See, e.g., *Snyder*, 131 N.E.3d at 653; *Haaland v. Presbyterian Health Plan, Inc.* (D.N.M. 2018) 292 F.Supp.3d 1222, 1230–1231.)

2. Review of coverage determinations.

Quishenberry's claims are not only contingent on federal standards for Medicare Part C. They also hinge solely on an allegedly premature discharge that should have been resolved under the Medicare exclusive-review provisions. According to the complaint, "GEM furnished Eugene with a false statement that he was no longer qualified *under Medicare* for further inpatient care at GEM." (1AA33 [SAC ¶ 26], italics added.) The federal standards for reviewing this coverage determination supersede state law that would submit such issues to a jury, rather than CMS.

Federal law establishes a four-tier review process for coverage determinations under MA plans, including the procedures guaranteed to the enrollee and the form and content of any denial by the MA organization. First, "[e]ach MA organization must have a procedure for making timely organization determinations" of the benefits guaranteed by the MA plan. (42 C.F.R. § 422.566(a); see § 422.566(c) [procedures available to "enrollee" and "legal representative of a deceased enrollee's estate"].) Second, an enrollee dissatisfied by the MA

organization's decision can request reconsideration (§§ 422.578, 422.582, 422.584) and then can appeal to "an independent, outside entity that contracts with CMS" for review of the dismissal of a reconsideration request (§ 422.592). Third, an enrollee whose claim meets the amount-in-controversy requirement "has a right to a hearing before an ALJ" (§ 422.600(a)) with a potential appeal to the Medicare Appeals Council (§ 422.608). And fourth, the enrollee can file in federal district court for judicial review of the agency's decision. (42 U.S.C. § 1395w-22(g)(5), incorporating 42 U.S.C. § 405(b); 42 C.F.R. § 422.612.)

Eugene or his representative could have invoked these procedures to review his entitlement under 42 U.S.C. § 1395d(a)(2) to additional daily care in a skilled nursing facility—the core of all of Quishenberry's claims. (See, e.g., *Hurley by Hurley v. Bowen* (2d Cir. 1988) 857 F.2d 907, 909–910; *Rapport*, 564 F.Supp.2d at 192; see also 42 C.F.R. § 409.31(b) [requirements for skilled nursing services].) Federal standards even establish special review provisions specifically for discharge from a skilled nursing facility. The enrollee can take a "fast-track appeal" to an independent review entity. (§ 422.626; see § 422.624(a)(1).) An enrollee whose discharge is upheld can request reconsideration and (if necessary) can appeal to the Office of Medicare Hearings and Appeals for an ALJ hearing, with down-the-line review by the Medicare Appeals Council and a federal court. (§ 422.626(g).)

Because the "organization determination" (such as a discharge) "is binding on *all* parties unless" reconsidered or revised under Medicare procedures (42 C.F.R. § 422.576, italics added), section 1395w-26(b)(3) preempts state claims that seek to litigate issues that could have been resolved through the review process. (See § 422.566(b) [definition of organization determination].) That is true even though Medicare likely does not provide a damages remedy after an enrollee's death. (See § 422.618; see also *McCall*, 25 Cal.4th at 421 & fn. 7.) Although Quishenberry seeks damages under state law, his "creatively-styled claims" are inescapably "seeking redress" for the denial of a Medicare benefit. (*Haaland*, 292 F.Supp.3d at 1234.) The "binding" effect of the organization determination (§ 422.576) means that a plaintiff cannot wait to bring a claim for damages once the enrollee can no longer enforce an MA plan through the Medicare review procedures, just as a plaintiff cannot bypass the ERISA cause of action by relabeling a claim brought under an ERISA plan as a tort claim. (*Davila*, 542 U.S. at 214–215.)

In Medicare Part C, Congress committed to the tradeoffs inherent in expedited yet comprehensive expert review with tailored remedies that allow MA organizations and the federal government "an opportunity to correct" mistaken coverage determinations before it is too late. (*Haaland*, 292 F.Supp.3d at 1234.) Quishenberry seeks to supplement Medicare with additional remedies, including compensation for pain and suffering, damages for medical expenses, and punitive damages. (1AA37.) But as the U.S. Supreme Court has similarly held for

ERISA, the congressional decision to limit the enrollee's remedies against MA plans through nationally uniform rules supersedes state law that "purport[s] to authorize a remedy unavailable under the federal provision." (*Pilot Life Ins. Co. v. Dedeaux* (1987) 481 U.S. 41, 55.) While this choice necessarily cuts off state-law remedies, CMS has the authority to impose sanctions or to terminate the MA plan if an MA organization fails "to provide medically necessary items and services that are required" by Medicare. (42 C.F.R. § 422.752(a)(1); see § 422.510.)

Critically, none of this means that section 1395w-26(b)(3) preempts tort claims against treating physicians, such as Dr. Lee. Although this appeal does not concern the trial court's denial of Dr. Lee's demurrer (or the viability of the claims that GEM settled), it bears mention that no federal standard appears to address the physician's standard of care. (See also 42 U.S.C. § 1395.) But Quishenberry has sued Respondents because they administered Eugene's MA plan, not because they practiced medicine contrary to professional standards. Put another way, a fundamental premise of preemption is that plaintiffs cannot bring state claims that "derive[] entirely from the particular rights and obligations established" by the MA plan. (*Davila*, 542 U.S. at 213.) Federal standards plainly have superseded state law as to claims against Respondents—an MA organization and its delegated administrators of an MA plan.[1]

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[1] Quishenberry has sued several UnitedHealthcare and Healthcare Partners entities, but he does not challenge the

3. Provider oversight.

Quishenberry also argues that Respondents acted negligently and committed elder abuse by not properly monitoring and controlling the healthcare decisions of their contracted providers. He contends that Respondents should have "interven[ed] to control GEM and Lee's treatment decision making." (1AA35 [SAC ¶ 41].) Here, too, federal standards displace state-law duties that regulate how MA organizations and their delegated administrators engage in oversight of providers.

Part C regulations impose detailed standards on the use of provider networks, including "skilled nursing facilities," as a way for MA organizations to fulfill their obligation to provide

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Court of Appeal's (correct) determination that the preemption analysis is the same with respect to all of them. (See Opn. at 14, fn. 8, 16–17.) Section 1395w-26(b)(3) prevents the application of state laws to individuals and entities administering MA plans when "the conduct underlying the[] allegations is directly governed by federal standards." (*Uhm*, 620 F.3d at 1158; see *Escarcega v. Verdugo Vista Operating Co.* (C.D.Cal., Apr. 8, 2020) 2020 WL 1703181, at *12–13.) To the extent any UnitedHealthcare entity did anything relevant to the case, it was only through offering and administering the MA plan as (or in conjunction with) the MA organization. (1AA27–28 [SAC ¶ 5]; see also *Morrison*, 328 P.3d at 1170–1171.) The complaint also targets Healthcare Partners entities for their role in administering Medicare benefits under Eugene's MA plan. (1AA29 [SAC ¶¶ 9–10].) Yet CMS directly regulates such downstream entities, which "are largely subject to the same requirements" as MA organizations when they administer MA plans. (*Escarcega*, 2020 WL 1703181, at *12; see 42 C.F.R. §§ 422.2, 422.504(i).)

adequate access to services covered by Medicare Parts A and B. (42 C.F.R. § 422.112(a)(1)(i).) These standards include "[p]rovider selection and credentialing" by MA organizations. (§ 422.204; see also §§ 422.200–422.224 ["Relationships with Providers"].) CMS then reviews each plan to make sure the network has a "sufficient number and range of health care professionals and providers willing to provide services under the terms of the plan." (42 U.S.C. § 1395w-22(d)(4); see 42 C.F.R. § 422.116(a)(1)(i).) Meanwhile, MA organizations must create "an ongoing quality improvement program" to monitor the performance of the plan and its providers of benefits and services. (§ 422.152(a); see § 422.504(a)(5).) And they must establish "meaningful procedures for timely hearing and resolving grievances between enrollees and the organization or any other entity or individual through which the organization provides health care services under any MA plan it offers." (§ 422.564(a).)

These federal standards for oversight and grievances supersede the state-law duties alleged in the complaint. Most prominently, Respondents were forbidden by federal law to interfere with Dr. Lee's advice to Eugene about "medical care or treatment for the individual's condition or disease, regardless of whether benefits for such care or treatment are provided under the plan, if the professional is acting within the lawful scope of practice." (42 U.S.C. § 1395w-22(j)(3); see 42 C.F.R. § 422.206(a)(1)(i); *Yarick*, 179 Cal.App.4th at 1164.) Federal law instead channels oversight of provider care through the formalized grievance process and quality-improvement program.

If state law imposed a duty on MA organizations to intervene in doctors' discharge decisions, such tort liability "would directly undermine the statute and regulations' directions that entities may not interfere with provider advice to enrollees." (*Escarcega v. Verdugo Vista Operating Co.* (C.D.Cal., Apr. 8, 2020) 2020 WL 1703181, at *12.)

The federal standards for removing physicians likewise supersede the tort claims in this case. While MA organizations have an ongoing duty under federal law to monitor the performance of physicians (42 C.F.R. § 422.202(b)), an MA organization can remove a physician from its network for "deficiencies in the quality of care" only after giving the physician notice and the opportunity to appeal to a hearing panel composed primarily of "peers of the affected physician" (§ 422.202(d)). CMS's adoption of expert review of providers preempts Quishenberry's attempt to have a jury composed of laypersons decide whether Respondents violated their alleged duty to monitor Dr. Lee and GEM. (See *Morrison*, 328 P.3d at 1170.)

4. The saving clause does not apply.

Quishenberry does not contend that his claims fall within the parenthetical saving clause "(other than State licensing laws or State laws relating to plan solvency)." (42 U.S.C. § 1395w-26(b)(3).) And any such contention would fail in any event. His claims have nothing to do with plan solvency. Nor do they concern state licensing laws.

The narrow exception for "licensing" laws preserves state laws that set eligibility requirements for entities that "offer

health insurance or health benefits coverage in each State." (42 C.F.R. § 422.400(a); see also *Whiting*, 563 U.S. at 595–597 [preemption statute that saves "licensing" laws allows state to "grant," "suspend," and "revoke" licenses].) Quishenberry has never argued that Respondents are not "licensed or otherwise authorized by the State to assume risk for offering health insurance or health benefits coverage, such that the entity is authorized to accept prepaid capitation for providing, arranging, or paying for comprehensive health services under an MA contract." (42 C.F.R. § 422.2; see *Yarick*, 179 Cal.App.4th at 1168.) His claims fall in the heartland of Medicare preemption, not in the outskirts of licensing law.

C. Section 1395w-26(b)(3) preempts even those state claims that parallel federal standards.

In his Opening Brief, Quishenberry attempts to explain away all the explicit invocations of federal Medicare standards in the complaint as the basis of his claims. He now contends he was simply piggybacking off those federal standards, because section 1395w-26(b)(3) permits state claims that "parallel federal requirements." (OB-10.) The Medicare Act's text, statutory history, and purpose all refute this position.

Start with the text. Again, federal standards "supersede *any* State law or regulation . . . with respect to MA plans which are offered by MA organizations." (42 U.S.C. § 1395w-26(b)(3), italics added.) This provision does not confine the preemptive effect of federal standards to only a subset of *inconsistent* state laws. On the contrary, "the word 'any' has an expansive

meaning, that is, 'one or some indiscriminately of whatever kind.'" (*Ali v. Federal Bureau of Prisons* (2008) 552 U.S. 214, 219, quotation marks omitted.) The statute thus preempts any state law "that duplicates, supplements, or supplants" the federal standards for MA plans. (*Davila*, 542 U.S. at 209; see *Pacificare of Nev., Inc. v. Rogers* (Nev. 2011) 266 P.3d 596, 601.)

To defend parallel regulation under state law, Quishenberry relies on *Riegel v. Medtronic, Inc.* (2008) 552 U.S. 312. (OB-10.) But that case—addressing a statute with "markedly different language" from the one here (OB-8)—only confirms that Quishenberry has misread section 1395w-26(b)(3). The statute in *Riegel* made the dispositive textual distinction that the statute here does not: it preempted state law only when "*different from*, or *in addition to*, any requirement applicable under this chapter." (21 U.S.C. § 360k(a), italics added.)

This difference between section 1395w-26(b)(3) and the statute in *Riegel* was intentional. As originally enacted, federal standards established under Part C would "supersede any State law or regulation" only "to the extent such law or regulation is *inconsistent with such standards*." (Balanced Budget Act of 1997, § 4001, 111 Stat. 319, italics added.) But Congress later expanded the scope of preemption by deleting the inconsistency requirement in an amendment titled "Avoiding *duplicative* state regulation." (Medicare Prescription Drug, Improvement, and Modernization Act of 2003, Pub.L. No. 108-173, § 232 (Dec. 8, 2003), 117 Stat. 2066, 2208, italics added.) In doing so, the Medicare Modernization Act "significantly broadened the scope of

Federal preemption of State law." (Establishment of Medicare Advantage Program, 70 Fed.Reg. 4663 (Jan. 28, 2005).) Quishenberry wants to read an "inconsistency" requirement back into the statute, nearly twenty years after Congress deliberately took it out. He overlooks that "courts must presume" that an amendment has "real and substantial effect." (*Ross v. Blake* (2016) 578 U.S. 632, 641–642, quotation marks omitted.)

Congress avowedly expressed its intention to displace all state regulation of MA plans. The Conference Report explains that the Medicare Modernization Act's amendment "clarifies that the MA program is a federal program operated under Federal rules. State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency." (H.R.Conf.Rep. No. 108-391, at 557.) So as courts have recognized, "Congress's purpose in enacting § 1395w-26(b)(3) was to protect the purely federal nature of Medicare Advantage plans operating under Medicare." (*First Medical Health Plan*, 479 F.3d at 52.)

In petitioning for this Court's review, Quishenberry mischaracterized the Ninth Circuit's decision in *Uhm* as holding that a "conflict with federal standards" is "necessary for a claim to be preempted" under section 1395w-26(b)(3). (PFR-21.) The Ninth Circuit had the opposite reaction to the amendment and conference report—"that Congress intended to expand the preemption provision beyond those state laws and regulations inconsistent with the enumerated standards." (620 F.3d at 1149–1150.) But for purposes of deciding the issues before it on appeal,

the Ninth Circuit needed to go no further than to recognize that the statute preempted the inconsistent state laws at issue in *Uhm*. (See *id.* at 1150.) *Uhm* hurts rather than helps Quishenberry's reading of the statute.

In sum, MA plans would lose their purely federal nature if state courts could do what Quishenberry proposes—adjudicate a plaintiff's entitlement to Medicare benefits or procedures as part of a state-law tort claim. (Cf. *Gobeille*, 577 U.S. at 326–327 ["single uniform national scheme for the administration of ERISA plans" preempts state laws "even when those laws, to a large extent, impose parallel requirements"].)

D. Section 1395w-26(b)(3) preempts generally applicable state law.

Quishenberry also argues that section 1395w-26(b)(3) does not preempt generally applicable state law, such as elder-law statutes or common-law tort duties. (OB-7.) He grounds his position in the statutory directive that federal standards established under Part C "shall supersede any State law or regulation *with respect to* MA plans which are offered by MA organizations." (42 U.S.C. § 1395w-26(b)(3), italics added.) According to Quishenberry, only "state laws aimed at" MA plans specifically—and not generally applicable legal standards or tort duties—can be state law "with respect to" an MA plan. (OB-9, italics deleted.)

Quishenberry misunderstands the function of "with respect to." It defines how far federal standards go in preempting state law—only as applied to MA plans, but not further to other health

insurance plans offered by MA organizations. (See *Pharm. Care Mgmt. Assn.*, 18 F.4th at 971; *Roberts*, 2 Cal.App.5th at 146–147.) Yet the phrase doesn't pave the way for state regulation of MA plans through generally applicable state laws that "implicate[] 'conduct that [is] governed by federal Medicare standards.'" (*Snyder*, 131 N.E.3d at 652, quoting *Haaland*, 292 F.Supp.3d at 1231; see, e.g., *Humana Medical Plan, Inc. v. Reale* (Fla.Ct.App. 2015) 180 So.3d 195, 209 [generally applicable subrogation law preempted "with respect to an [MA organization's] reimbursement rights"].) In other words, the phrase "with respect to" limits the extent of preemption to MA plans but does not reserve preemption for the (apparently nonexistent) universe of state laws that regulate only MA plans.

Respondents break no new ground with their interpretation of the phrase "with respect to." The U.S. Supreme Court interpreted the same phrase the same way in the Medical Devices Amendments of 1976, which states that "no State or political subdivision of a State may establish or continue in effect *with respect to a device intended for human use* any requirement" related to safety or effectiveness that is different from or in addition to federal requirements. (21 U.S.C. § 360k(a), italics added.) In *Riegel*, the Court held that the phrase "with respect to" does not "suggest[] that the pre-empted state [law] must apply *only* to the relevant device, or only to medical devices and not to all products and all actions in general." (552 U.S. at 328, original italics.) The more natural reading is that "general tort duties" are preempted "'with respect to'" the device. (*Ibid*.)

So too here. Indeed, Quishenberry candidly recognizes that section 1395w-26(b)(3) would be a nullity on his reading because "no state law appears to apply specifically *to a Medicare plan*." (PFR-21, original italics.) So he switches to arguing that the statute preempts state law that specifically regulates HMO plans (rather than just MA plans)—a shift intended, in part, as a launching pad for his further argument that preemption works only in *his* favor to clear away Respondents' state-law defense against vicarious liability under the Knox-Keene Act. (See OB-9; PFR-31; see also 1AA29–30 [SAC ¶ 15].) Yet that interpretation cannot be squared with the statutory language "with respect to MA plans." After all, most HMO plans are not MA plans, and not all MA plans are HMO plans. The right answer, as the Ninth Circuit has held, is much simpler: Quishenberry has invoked "general tort duties 'with respect to'" an MA plan, and such duties need not apply only to MA plans (or only to HMO plans) to qualify for preemption under section 1395w-26(b)(3). (*Riegel*, 552 U.S. at 328; see *Uhm*, 620 F.3d at 1150, fn. 25.)

Like the U.S. Supreme Court, this Court has recognized that the phrase "with respect to" is "broad language preempting all state regulation, laws, or remedies relating to, concerning, or merely touching on the issue at hand." (*Solus*, 4 Cal.5th at 337–338, citing 21 U.S.C. § 360k(a); 49 U.S.C. § 14501(c)(1).) At the very least, Quishenberry's claims *touch on* the administration of MA plans. And as this Court suggested in *Solus*, the breadth of "with respect to" is comparable to the phrase "relate to" in ERISA's preemption provision. (See *id.* at 338, citing 29 U.S.C.

§ 1144(a).) Under ERISA, "a state law may 'relate to' a benefit plan, and thereby be pre-empted, even if the law is not specifically designed to affect such plans, or the effect is only indirect." (*Ingersoll-Rand Co. v. McClendon* (1990) 498 U.S. 133, 139.) Section 1395w-26(b)(3) operates the same way for MA plans, as *Riegel* shows.

Moreover, Congress's decision to expand the Medicare Part C preemption statute underscores its breadth. The prior version of the statute specified three categories of state laws that were specifically superseded by federal standards: benefit requirements, requirements relating to inclusion or treatment of providers, and coverage determinations. (Balanced Budget Act of 1997, § 4001, 111 Stat. 319.) In enacting the amendments of the Medicare Modernization Act in 2003, Congress took the opposite tack by superseding all state law with respect to MA plans, except for two carveouts inapplicable here. (See *Roberts*, 2 Cal.App.5th at 143.)

This amendment was supposed to clear up "some confusion in recent court cases" by "clarif[ying] that the MA program is a federal program operated under Federal rules" to which state laws "should not apply." (H.R.Conf.Rep. No. 108-391, at 557.) The legislative history does not refer to any particular case, but some courts had held that state tort remedies escaped preemption so long as the claims did "not seek payment or reimbursement of a Medicare claim or otherwise fall within the Medicare administrative review process for coverage determinations." (*Zolezzi v. PacifiCare of Cal.* (2003) 105

Cal.App.4th 573, 586; see Reed, *Medicare Advantage Misconceptions Abound* (2014) 27 Health Lawyer 1, 4, fn. 38 ["little doubt" that this Court's decision in *McCall* motivated amendment to section 1395w-26(b)(3)].) Now, by contrast, "State standards are presumed preempted unless they are licensing or solvency laws." (Establishment of Medicare Advantage Program, 70 Fed.Reg. 4680.)

Quishenberry's attempt to exclude generally applicable state laws would paradoxically *shrink* the scope of section 1395w-26(b)(3) relative to the narrower 1997 version. His claim that Eugene was denied his Medicare benefit of skilled nursing care undoubtedly "relat[es] to" "[b]enefit requirements" of Medicare Part C and "[c]overage determinations" by Respondents. (Balanced Budget Act of 1997, § 4001, 111 Stat. 319; see *Massachusetts Assn. of Health Maintenance Orgs. v. Ruthardt* (1st Cir. 1999) 194 F.3d 176, 185.) Consider, too, that Eugene could have sought review of his discharge through expedited Medicare procedures (42 C.F.R. § 422.626), which would have readily established preemption under the Balanced Budget Act of 1997 (*Zolezzi*, 105 Cal.App.4th at 586). In expanding the preemptive scope of Medicare Part C, Congress did not shear away the prohibition on state regulation of MA plan benefits through generally applicable standards.

Although the phrase "with respect to" is broad, section 1395w-26(b)(3) has important limits. The synonymous term "related to" does not supersede state laws that affect the federal area "'in too tenuous, remote, or peripheral a manner' to have

pre-emptive effect." (*Morales*, 504 U.S. at 390.) The same holds true for "with respect to MA plans." Because Medicare Part C and its implementing regulations "establish[ ] standards and set[ ] forth the requirements, limitations, and procedures *for Medicare services* furnished, or paid for, by Medicare Advantage organizations through Medicare Advantage plans" (42 C.F.R. § 422.1(b), italics added), federal standards do not displace state law as applied to activities by MA organizations outside Medicare Part C. The preemption provision therefore does not apply, for example, when an MA organization participates in a *Medicaid* program (see *First Medical Health Plan*, 479 F.3d at 52) or offers a non-MA plan.

E. Section 1395w-26(b)(3) does not exempt common-law duties from preemption.

Quishenberry also contends that section 1395w-26(b)(3) preempts only positive enactments. In his view, the phrase "law or regulation" does not encompass common-law duties, which (if true) would save his negligence claims, but not his statutory claim for elder abuse. (OB-7.) The Fourth and Fifth Districts have accepted this argument following a cursory analysis of *Sprietsma v. Mercury Marine* (2002) 537 U.S. 51. (See *Cotton*, 183 Cal.App.4th at 450; *Yarick*, 179 Cal.App.4th at 1165, 1167.) This Court should reject it.

The interpretation adopted in *Cotton* and *Yarick* rests exclusively on a flawed reading of *Sprietsma*. That decision limited the scope of preemption to positive state enactments only because several distinctive features of the boating equipment

statute combined to overcome the general rule that "the phrase 'state law'" encompasses "common law as well as statutes and regulations." (*Cipollone v. Liggett Grp., Inc.* (1992) 505 U.S. 504, 522 [plur. opn. of Stevens, J.], citing *Erie R. Co. v. Tompkins* (1938) 304 U.S. 64.) As the Second District has explained, the courts in *Cotton* and *Yarick* failed to appreciate significant differences between the statute in *Sprietsma* and the Medicare preemption statute here. (*Roberts*, 2 Cal.App.5th at 145–146.) Respondents' interpretation is most faithful to the text of section 1395w-26(b)(3), the structure of Medicare Part C, and the regulatory history within CMS.

1. The text of section 1395w-26 lacks the crucial features that led *Sprietsma* to limit preemption to positive enactments.

Sprietsma concerned a statute that provided that States "may not establish, continue in effect, or enforce *a law or regulation* establishing a recreational vessel or associate equipment performance or other safety standard or imposing a requirement for associated equipment." (46 U.S.C. § 4306, italics added.) The U.S. Supreme Court held that this provision preempts only "positive enactments," such as statutes and regulations. (*Sprietsma*, 537 U.S. at 63.)

The Court offered two textual reasons for its self-consciously "narrow" interpretation of the preemption provision. (*Sprietsma*, 537 U.S. at 63.) First, the use of "the article 'a' before 'law or regulation' implies a discreteness—which is embodied in statutes and regulations—that is not present in the common

law." (*Ibid.*) And second, an interpretation of the term "law" that included the common law might "render the express reference to 'regulation' in the pre-emption clause superfluous." (*Ibid.*)

More so than these textual features, "[t]he *Sprietsma* decision placed substantial weight on the Boat Safety Act's saving provision." (*Northwest, Inc. v. Ginsberg* (2014) 572 U.S. 273, 283.) The Act provided that "[c]ompliance with this chapter or standards, regulations, or orders prescribed under this chapter does not relieve a person from liability at common law or under State law." (46 U.S.C. § 4311(g).) Under prior precedent, this sort of "'saving clause assumes that there are some significant number of common-law liability cases to save.'" (*Sprietsma*, 537 U.S. at 63, quoting *Geier v. Am. Honda Motor Co.* (2000) 529 U.S. 861, 868.) The *Sprietsma* opinion therefore interpreted the saving clause to preserve compensatory claims, leaving the preemption provision narrowly cabined to "performance standards and equipment requirements imposed by statute or regulation." (537 U.S. at 63–64.)

The text of section 1395w-26(b)(3) is very different from the statute interpreted in *Sprietsma*. Congress preempted "*any* State law or regulation." (42 U.S.C. § 1395w-26(b)(3), italics added.) As noted earlier, "the word 'any' has an expansive meaning, that is, 'one or some indiscriminately of whatever kind.'" (*Ali*, 552 U.S. at 219, quotation marks omitted.) Common law unquestionably is a kind of state law. (*Erie*, 304 U.S. at 78; see *Ginsberg*, 572 U.S. at 282 ["a common-law rule clearly has 'the force and effect of law'"].) And unlike the article "a," "any" does

not imply discreteness. (See *Uhm*, 620 F.3d at 1153.) A speaker might balk at describing a duty in negligence as "a" law, but surely no one would insist that the duty is not "any" law at all. (See *AT&T*, 562 U.S. at 406 ["two words together may assume a more particular meaning"]; cf. *Niz-Chavez v. Garland* (2021) 141 S.Ct. 1474, 1481.)

The nearest analogue for section 1395w-26(b)(3) is not the statute in *Sprietsma*, but the statute in *CSX Transp., Inc. v. Easterwood* (1993) 507 U.S. 658. The latter (since-repealed) statute preempted "*any* state 'law, rule, regulation, order, or standard relating to railroad safety'" when the Secretary of Transportation had issued a regulation on the same subject. (*Id.* at 664, italics added.) The Supreme Court held that this provision preempted "[l]egal duties imposed on railroads by the common law." (*Ibid.*) That was so even though the statute enumerated types of positive enactments after the general reference to state "law"—an interpretation that should apply with equal force here. (See also *Norfolk & Western R. Co. v. Train Dispatchers* (1991) 499 U.S. 117, 128 ["the phrase 'all other law'" does not distinguish between "positive enactments and common-law rules of liability"].)

The context of section 1395w-26(b)(3) also parts ways with the context underlying *Sprietsma*. Like the Federal Boat Safety Act, Medicare Part C contains a saving clause, but this clause does *not* preserve common-law actions with respect to MA plans. (See *Roberts*, 2 Cal.App.5th at 146.) Congress instead singled out "licensing laws" and "laws relating to plan solvency" for special

treatment. (42 U.S.C. § 1395w-26(b)(3).) If Congress had intended that same solicitude for common-law remedies, the phrase "any State law or regulation" (*ibid.*) would have been a puzzlingly oblique way to limit preemption to positive enactments.

Congress knows how to speak clearly when it wishes to carve out state common law from the scope of a preemption clause. (See, e.g., *Sprietsma*, 537 U.S. at 63; *Geier*, 529 U.S. at 867–868; *American Airlines, Inc. v. Wolens* (1995) 513 U.S. 219, 232–233.) Absent such a saving clause, a preemption provision should apply the same way to common-law duties as statutory ones whether the statute refers to "law" (see *Easterwood*, 507 U.S. at 664, citing *Cipollone*, 505 U.S. at 522 [plur. opn.]; see also *Pilot Life*, 481 U.S. at 47 [Congress's directive that ERISA supersedes "any and all State laws" preempts common-law claims]) or a related term like "requirements" (*Riegel*, 552 U.S. at 324; see also OB-9).

Respondents' interpretation of "any State law or regulation" does not render the word "regulation" superfluous. To be sure, the Supreme Court ruminated in *Sprietsma* that an interpretation of "law" that included the common law "*might* also be interpreted to include regulations" on its own. (537 U.S. at 63, italics added). Yet Congress didn't have to leave that possibility open to chance. While the term "law," standing alone, sometimes includes regulations (see, e.g., *Chrysler Corp. v. Brown* (1979) 441 U.S. 281, 295 & fn. 18), courts have also excluded regulations from the term depending on context (see, e.g., *Dept. of Homeland

Sec. v. MacLean (2015) 574 U.S. 383, 393–394; *Dept. of Treasury, IRS v. FLRA* (1990) 494 U.S. 922, 932). So the addition of "regulation" could "have simply [been] intended to remove any doubt" about the breadth of preemption (*Ali*, 552 U.S. at 226)—a belt-and-suspenders approach that is hardly unusual for a preemption provision (see, e.g., *Easterwood*, 507 U.S. at 664). That Congress adopted an arguable redundancy "to be doubly sure" of achieving its objective is no reason to reject the best reading of the statute. (*Barton v. Barr* (2020) 140 S.Ct. 1442, 1453.)

Small wonder, then, that *Cotton* and *Yarick* stand alone in their interpretation of section 1395w-26(b)(3). The other courts to consider the question have had no trouble distinguishing *Sprietsma*. (See, e.g., *Roberts*, 2 Cal.App.5th at 145–146; *Estate of Ethridge v. Recovery Mgmt. Systems, Inc.* (Ariz.Ct.App. 2014) 326 P.3d 297, 304–305; *Uhm*, 620 F.3d at 1153–1154.) This Court should distinguish it, too.

2. The structure and purpose of Medicare Part C do not support a carveout for common-law duties.

Respondents also offer the better interpretation in light of the statutory scheme. Nothing in the structure or purpose of Medicare Part C suggests that "Congress intended to save any common law claims." (*Uhm*, 620 F.3d at 1153.) Quite to the contrary, Congress acted to ensure that MA plans are federal plans *not* subject to "duplicative state regulation." (Medicare Modernization Act, § 232, 117 Stat. 2208; see H.R.Conf.Rep. No.

108-391, at 557.) Courts have thus recognized that the "legislative history shows that the Act's preemption provision has been specifically amended to include generally applicable common law." (*Rogers*, 266 P.3d at 601; see *Snyder*, 131 N.E.3d at 652–653.)

Whether in the form of a statute or the common law, state law that enters areas governed by federal standards would have the same adverse effect on the uniform Medicare Part C scheme. (See *Riegel*, 552 U.S. at 324.) Exempting common-law duties from section 1395w-26(b)(3) thus would undercut Congress's attempt to safeguard the uniform federal administration of MA plans. (See *Uhm*, 620 F.3d at 1156.) Quishenberry has offered no reason to believe "that Congress was concerned enough about the risks to federal standards governing MA plans posed by application of state statutes and regulations to expressly preempt their application but was unconcerned about the greater risks of inconsistency and variability posed by the application of state common law." (*Rudek v. Presence Our Lady of Resurrection Medical Ctr.* (N.D.Ill., Oct. 27, 2014) 2014 WL 5441845, at *4.) Because the purpose of section 1395w-26(b)(3)—protecting the federal scheme for MA plans—"can be undermined just as surely by a state common-law rule as it can by a state statute or regulation," what matters "is the effect of a state law, regulation, or provision, not its form." (*Ginsberg*, 572 U.S. at 283; see, e.g., *Kurns v. Railroad Friction Prods. Corp.* (2012) 565 U.S. 625, 637.)

3. CMS guidance supports the preemption of state common law.

Regulatory practice reinforces that Medicare Part C standards supersede state common-law duties as well as state statutory and regulatory requirements. (See *Ethridge*, 326 P.3d at 305.) Interpreting section 1395w-26(b)(3), CMS has declared that "all State standards, *including those established through case law*, are preempted to the extent they specifically would regulate MA plans, with exceptions of State licensing and solvency laws." (Establishment of Medicare Advantage Program, 70 Fed.Reg. 4665, italics added.) CMS had similarly interpreted the Balanced Budget Act of 1997 to preempt at least some common-law claims. (See *Uhm*, 620 F.3d at 1155, citing Medicare+Choice Program, 65 Fed.Reg. 40261 (June 29, 2000).)

On this point, the *Cotton* decision committed another misstep. The Fourth District relied on guidance in a proposed CMS rule that Congress intended to preempt only "'statutes enacted by legislators or regulations promulgated by State officials,'" as opposed to "'case law precedents established by courts.'" (183 Cal.App.4th at 450, quoting Proposed Rule for Establishment of Medicare Advantage Program, 69 Fed.Reg. 46914 (Aug. 3, 2004).) But well before *Cotton*, CMS had recanted this suggestion, which had "attracted a number of critical comments," and took the *opposite* stance in its final rule. (*Uhm*, 620 F.3d at 1156; see Establishment of Medicare Advantage Program, 70 Fed.Reg. 4665.) Sometimes the expert views of an agency will prove persuasive for the interpretation of a statute

within its regulatory ambit. (See *Skidmore v. Swift & Co.* (1944) 323 U.S. 134, 140.) But Respondents are not aware of any doctrine that lends credence to *discarded* views put forward in a *proposed* rule, especially when the agency rejects its unpersuasive first opinion and promulgates a contrary rule.

II. The claims are an obstacle to the purposes and objectives of the Medicare Act.

For the reasons given above, Quishenberry's claims are expressly preempted by federal standards promulgated under the Medicare Part C. But even if this Court determines that section 1395w-26(b)(3) does not expressly preempt all of Quishenberry's claims, it should hold that the Medicare Act and its implementing regulations impliedly preempt the claims.

Importantly, the existence of an express preemption provision "'does *not* bar the ordinary working of conflict pre-emption principles,'" including obstacle preemption. (*Sprietsma*, 537 U.S. at 65, quoting *Geier*, 529 U.S. at 869, original italics; see *Freightliner Corp. v. Myrick* (1995) 514 U.S. 280, 287–289.) Implied preemption is hardwired into the Constitution itself—specifically, the Supremacy Clause. (See *Crosby v. Nat. Foreign Trade Council* (2000) 530 U.S. 363, 387–388.) So the fact that Congress has made its preemptive intent explicit as to some state laws doesn't "create some kind of 'special burden' beyond that inherent in ordinary pre-emption principles" as to other state laws. (*Geier*, 529 U.S. at 870; see *Arizona v. United States* (2012) 567 U.S. 387, 406.)

Quishenberry's claims stand as "an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." (*Hines v. Davidowitz* (1941) 312 U.S. 52, 67.) This conclusion—that the alleged state-law duties conflict with Medicare—follows from "examining the federal statute as a whole and identifying its purpose and intended effects." (*Crosby*, 530 U.S. at 373.)

The first step is to "ascertain the nature of the federal interest" underlying Medicare Part C. (*Hillman v. Maretta* (2013) 569 U.S. 483, 491.) Here, Congress made clear its objective that "State laws, do not, and should not apply, with the exception of state licensing laws or state laws related to plan solvency." (H.R.Conf.Rep. No. 108-391, at 557.) CMS also has exercised its rulemaking authority in line with this goal of "ensuring that the MA program as a Federal program will operate under Federal rules." (Establishment of Medicare Advantage Program, 70 Fed.Reg. 4664; see *Quesada*, 62 Cal.4th at 317–318 ["agency's views" get "considerable weight" when "some aspects of the subject matter are recondite"].)

Quishenberry's claims threaten this federal interest in at least three distinct ways. First, allowing state courts (or state juries) to revisit coverage determinations would interfere with the uniform administration of Medicare benefits. Second, Quishenberry takes aim at the capitated payments received by Respondents for administering Medicare benefits, but Congress both incorporated capitation into Medicare Part C and forbade entities receiving capitated payments to intervene in the

provider's medical advice. And third, Eugene or a representative could have challenged his discharge as premature through the four-tier Medicare review procedures. CMS would lose control over policy decisions and technical issues alike if plaintiffs could litigate their claims in state court by waiting until federal remedies are no longer available. Each of these obstacles is an independent basis to affirm the judgment in full.

The obstacles created by this case amply rebut the presumption against preemption (which is, again, applicable only to implied preemption (see ante, at 33)). Given the risk that "leaving state law in place would compromise [the] objectives" of Medicare Part C, there is little reason to believe that Congress was "content to let that law remain as it was." (*Quesada*, 62 Cal.4th at 312.)

A. The uniform administration of Medicare benefits.

Quishenberry's claims present an obstacle to the uniform administration of Medicare benefits. Most plainly, the Medicare Act preempts the claims to the extent that he tries to enforce Medicare benefits in state court. Quishenberry does not disguise that his claims are "based on federal standards." (OB-10.) But CMS—not a jury—is the appropriate decisionmaker to apply these federal standards in a uniform manner. (See *Heckler v. Ringer* (1984) 466 U.S. 602, 614.) Put another way, Medicare Part C does not envision "cooperation and concurrent jurisdiction" between the federal government and the States with

respect to the adjudication of the right to Medicare benefits. (*Solus*, 4 Cal.5th at 340.)

The Medicare Act also preempts the claims to the extent Quishenberry tries to enforce benefits in addition to his MA plan. Throughout the complaint, Quishenberry alleges that Respondents had a duty to provide "custodial care" to Eugene. (1AA28–29, 34 [SAC ¶¶ 7, 35].) But Medicare does *not* cover custodial care. (42 U.S.C. § 1395y(a)(9); see *Hurley*, 857 F.2d at 911.) Instead, Medicare pays for skilled nursing care as a hospital benefit only when the need for in-patient treatment meets specific requirements. (42 C.F.R. § 409.31; see *United HealthCare Ins. Co. v. Sebelius* (D.Minn. 2011) 774 F.Supp.2d 1014, 1019.) And MA plans can offer only Medicare benefits and such supplemental benefits as are approved by the Secretary of Health and Human Services. (42 U.S.C. § 1395w-22(a).) So Quishenberry seeks either to enforce this limited Medicare benefit (which must be done through federal channels) or to compel Respondents to expand coverage beyond Medicare (which would pose an obstacle to the uniform administration of MA plans). (See *Egelhoff v. Egelhoff* (2001) 532 U.S. 141, 148.)

In *Yarick*, the Fifth District held that the Medicare Act impliedly preempts the same state-law duties asserted in this case. The plaintiff there made materially identical claims—that the MA organization breached its duty to provide necessary medical care to the enrollee and its "duty to exercise due diligence to ensure that its providers were providing adequate care." (179 Cal.App.4th at 1164–1165.) But those claims posed

an obstacle to CMS's authority to review MA plans to ensure that they provide adequate access to covered services. (See 42 C.F.R. §§ 422.256(b)(2), 422.503(d), 422.505(c).) The court in *Yarick* worried that "[i]f state common law judgments were permitted to impose damages on the basis of these federally approved contracts and quality assurance programs, the federal authorities would lose control of the regulatory authority that is at the very core of Medicare generally and the MA program specifically." (179 Cal.App.4th at 1167–1168.)

The concern expressed in *Yarick* about executive control over federally approved MA plans is justified—and an ample basis for obstacle preemption. (See, e.g., *Arizona*, 567 U.S. at 402; *Crosby*, 530 U.S. at 381.)

B. The congressional policy judgment to adopt a capitation model for Medicare Part C.

The claims in this case also present an obstacle to—indeed, they are an attack on—the capitation model that Congress adopted in Medicare Part C. As detailed earlier, MA organizations receive a capitated rate for each MA plan member—i.e., "a fixed per enrollee per month amount" set on an annual basis by CMS "for contracted services without regard to the type, cost, or frequency of services furnished." (42 C.F.R. § 422.350(b); see § 422.306.) MA organizations, in turn, can pay participating providers a capitated rate to care for members of the MA plans. (See 42 U.S.C. § 1395w-25(b)(4).) Because the actual expenses for the enrollee may be more or less than the fixed payment, the capitated entities "assume full financial risk

on a prospective basis for the provision of the health care services for which benefits are required to be provided." (§ 1395w-25(b).)

A central theme of Quishenberry's complaint is that capitation, by pushing insurance risk downstream (ultimately to contracted providers), encourages healthcare entities "to identify and exploit opportunities to reduce the cost of care to enrollees." (1AA31 [SAC ¶ 16]; see 1AA30–31, 1AA36 [SAC ¶¶ 13, 17, 43, 48].) But it was *Congress* that endorsed a capitation model to achieve the perceived benefits of the HMO model. (Balanced Budget Act of 1997, § 4001, 111 Stat. 315; see H.R.Conf.Rep. No. 105-217, at 585.) In doing so, Congress followed a standard practice in the healthcare industry—one that many advocate as a counterbalance to the fee-for-service incentive to recommend "more aggressive treatment" that "is not in the patient's best interest." (*Pegram*, 530 U.S. at 234.)

Perhaps Quishenberry could hypothesize "plausible reasons to favor a different policy" than capitation, "[b]ut that is not the judgment Congress made" in Medicare Part C. (*Hillman*, 569 U.S. at 494–495.) Allowing a jury to hold any capitated entity liable for this supposed conflict of interest certainly "would compromise" the congressional objective to administer Medicare Part C through MA plans. (*Quesada*, 62 Cal.4th at 312.)

In addition to his frontal challenge to capitation, Quishenberry also alleges state-law duties that conflict with federal law. He contends that Respondents violated state law by not intervening to stop Dr. Lee's discharge order. (1AA33, 1AA35 [SAC ¶¶ 29, 41].) But entities receiving capitated payments as

part of Medicare Part C cannot interfere in medical decisions of healthcare providers. (See 42 U.S.C. § 1395w-22(j)(3); 42 C.F.R. §§ 422.206, 422.208(c)(1), 422.504(a)(6).) These statutes and regulations serve as an ethical precaution by keeping the risk-bearing insurer *out* of the treatment decision. (See *Yarick*, 179 Cal.App.4th at 1163–1164.) Thus, as even the complaint concedes, Respondents were "obligated by law to refrain from making health care decisions, or to influence health care decisions, and were instead to leave health care providers including physicians" and skilled nursing facilities "free to make health care decisions solely in the patient's interest." (1AA28 [SAC ¶ 6].)

State law cannot force capitated entities to intervene in healthcare decisions when federal law prohibits such interference. (See *Yarick*, 179 Cal.App.4th at 1164.) In fact, this conflict goes beyond a mere obstacle because the alleged state-law duty to intervene creates an "inevitable collision with" the federal non-interference rules. (*Florida Lime & Avocado Growers, Inc. v. Paul* (1963) 373 U.S. 132, 143.) The clash between these commands is no different from, say, a state-law duty to change a drug label whose content is mandated by federal law. There, like here, federal law demands inaction from the regulated party and thereby preempts state law that compels action. (See *PLIVA, Inc. v. Mensing* (2011) 564 U.S. 604, 618.) Principles of impossibility preemption therefore reinforce the Court of Appeal's holding that Quishenberry's claims are preempted as an obstacle to Medicare's

provider oversight rules. (See *Crosby*, 530 U.S. at 372, fn. 6 ["the categories of preemption are not 'rigidly distinct'"].)

C. The exclusive-review provisions for Medicare claims.

Finally, the Medicare Act impliedly preempts Quishenberry's claims because Eugene could have sought review of his discharge through the Medicare exclusive-review provisions. (See, e.g., *Matthews*, 452 F.3d at 148–150.) As explained above, federal regulations establish special review procedures for discharges from skilled nursing facilities. (42 C.F.R. § 422.626; see ante, at 39.) The MA organization bears the burden of proof to show that the discharge "is the correct decision, either on the basis of medical necessity or based on other Medicare coverage policies." (§ 422.626(c).) The independent review entity must make its decision within one calendar day after receiving the pertinent materials. (§ 422.626(d)(5).) Only the enrollee can appeal an adverse decision up through CMS all the way to federal court. (§ 422.626(g)(3).)

This process not only guarantees a prompt opportunity to undo mistaken discharges, but also safeguards the federal agency's authority. The "'channeling' of virtually all legal attacks" through CMS "assures the agency greater opportunity to apply, interpret, or revise policies, regulations, or statutes without" the risk of "interference by different individual courts." (*Shalala v. Illinois Council on Long Term Care, Inc.* (2000) 529 U.S. 1, 13.) If plaintiffs could submit Medicare coverage

determinations to juries in subsequent tort litigation, CMS would soon lose its grip over the MA program. (Cf. *Ringer*, 466 U.S. at 615–616.)

The Medicare review scheme reflects a careful compromise. Congress made sure that enrollees had all the necessary resources at their disposal on the front end to challenge coverage decisions with prompt remedies available in the event of an error. (See 42 C.F.R. §§ 422.618, 422.626.) Review in federal court also stands as a backstop if CMS misapplies federal standards. (See 42 U.S.C. § 1395w-22(g)(5).) Thus, if enrollees utilize these procedures, the congressionally designated decisionmakers can fix coverage determinations before they materialize in damages. This preference for immediate review and prompt correction explains Congress's decision not to provide damages remedies beyond reimbursement under the MA plan. (See 42 C.F.R. § 422.618.) As the U.S. Supreme Court has observed for ERISA, "[t]he limited remedies" under that statute "are an inherent part of the 'careful balancing' between ensuring fair and prompt enforcement of rights under a plan and the encouragement of the creation of such plans." (*Davila*, 542 U.S. at 215.)

The Medicare review procedures are not the opening act for subsequent litigation of Medicare issues through the prism of state tort law. CMS regulations make "[t]he organization determination binding on all parties unless it is reconsidered under §§ 422.578 through 422.596 or is reopened and revised under § 422.616." (42 C.F.R. § 422.576; see *Global Rescue Jets, LLC v. Kaiser Foundation Health Plan, Inc.* (9th Cir., Apr. 8,

2022) — F.4th —, 2022 WL 1052671, at *11.) Of course, Medicare enrollees may have an after-the-fact tort remedy against the treating physician for breach of the professional standard of care—an issue of state law that is *not* governed by Medicare standards. (See ante, at 41.) But it would frustrate the congressional objective of uniform review of coverage determinations if enrollees or their representatives could seek state remedies against MA plan administrators by forgoing Medicare procedures until they no longer offer an effective federal remedy. (See *Haaland*, 292 F.Supp.3d at 1234; see also *Davila*, 542 U.S. at 210.) State law that adds tort remedies for the administration of MA plans therefore "conflicts with Congress' clear intent to make" review under Medicare "exclusive." (*Davila*, 542 U.S. at 214, fn. 4.)

It bears mention that Quishenberry does not rely on this Court's decision in *McCall*; there are at least two good reasons for that.

First, his claims are fundamentally different. In *McCall*, the Court held that the Medicare Act did not impliedly preempt state tort claims that were "unrelated" to "Medicare coverage determinations." (25 Cal.4th at 425.) Quishenberry's claims, by contrast, are much more than "incidentally related to the wrongful denial of a benefits claim" (*id.* at 419)—the allegedly premature discharge is the crux of the case (e.g., 1AA33 [SAC ¶¶ 26–29]). The fact that Eugene's discharge could have been reviewed under Medicare makes this case the opposite of *McCall*,

where there was no potential for administrative review of the "forced disenrollment" of the plaintiff. (25 Cal.4th at 424.)

Second, *McCall* predated the express preemption provision enacted in Medicare Modernization Act. As this Court suggested, the result in *McCall* would have been different for a statute like ERISA, a "classic example of clear congressional intent to preempt state remedies." (25 Cal.4th at 422, citing 29 U.S.C. § 1144(a).) Congress took that step by enacting similar language in Medicare Part C, thereby signaling its desire for broad preemption. (See ante, at 46–47.) As it now stands, "the federal statute as a whole" demonstrates good "reason to discount the possibility the Congress that enacted the legislation was aware of the background tapestry of state law and content to let that law remain as it was." (*Quesada*, 62 Cal.4th at 312, quotation marks omitted.)

Accordingly, section 1395w-26(b)(3) should inform the implied preemption analysis even if this Court does not agree with Respondents that the statute, by its plain terms, preempts the claims in this case. (See *Davila*, 542 U.S. at 217 ["congressional intent to create an exclusive federal remedy" reinforces conflict principles]; cf. *McCall*, 25 Cal.4th at 346 [formerly "limited" preemption provision of Balanced Budget Act militated against implied preemption].) At present, all signs—both express and implied—in Medicare Part C point to the conclusion that federal law preempts Quishenberry's claims.

CONCLUSION

The Court should affirm the judgment of the Court of Appeal. If this Court is inclined to reverse on preemption grounds, it should remand for the Court of Appeal to consider Respondents' alternative grounds for affirmance. (Opn. at 24, fn. 12; see, e.g., *Yamaha Corp. of Am. v. State Bd. of Equalization* (1998) 19 Cal.4th 1, 15.)

DATED: April 18, 2022

Respectfully Submitted,

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Under Rule 8.204(c)(1) of the California Rules of Court, the undersigned hereby certifies that this answer brief contains 13,996 words, as counted by Microsoft Word, excluding the tables, this certificate, and the signature blocks.

Dated: April 18, 2022

Kahn A. Scolnick

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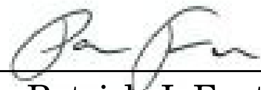

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