No. S271501

In the Supreme Court of the State of California

LARRY QUISHENBERRY,
Plaintiff and Appellant,

v.

UNITED HEALTH CARE, INC., ET AL.,
Defendants and Respondents.

Second Appellate District, Case No. B303451
Los Angeles County Superior Court, Case No. BC631077
Hon. Ralph Hofer, Judge

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STATEMENT OF INTEREST

This case presents the questions of whether the federal Medicare Modernization Act expressly or impliedly preempts certain state claims asserted by a private plaintiff against a Medicare Advantage (MA) plan. The Attorney General is the State's chief law officer charged with enforcing state consumer protection and other health and safety laws. An unduly broad reading of the preemptive scope of the federal Act could improperly interfere with the Attorney General's ability to enforce health and safety statutes, regulations, and other legal obligations that protect Medicare beneficiaries and the workers who provide healthcare services to them. Therefore, although this brief does not take a position regarding the disposition of the Plaintiff's claims in this case, the Attorney General has a direct and substantial interest in the Court's articulation of the scope of MA preemption under federal law. This brief is submitted pursuant to California Rules of Court, rule 8.520, subdivision (f)(8).

INTRODUCTION

Medicare provides healthcare services to some of California's most medically vulnerable residents. Millions of California Medicare beneficiaries are enrolled in Medicare Advantage, which provides for the delivery of Medicare benefits through private insurance organizations rather than through Medicare's traditional fee-for-service model. Defendants' answer brief emphasizes the extent of federal control over the Medicare Advantage program, but does not address the interests and

authority of state law and state agencies in protecting the health and safety of all patients, including those whose care is delivered through Medicare Advantage. State laws like the Elder Abuse Act, and similar laws of general applicability, impose obligations on MA plans and their contractors as they do on all entities operating within California.

The federal Medicare Modernization Act provides that the "standards established under" Part C of the larger Medicare Act "shall supersede any State law[s] and regulation[s] […] with respect to MA plans." (42 U.S.C. § 1395w-26(b)(3).) In adopting that provision, Congress did not intend to provide MA plans with blanket immunity from basic health and safety obligations grounded in state law that apply to all persons and entities statewide, or other generally applicable laws that do not undermine the administration of the federal MA program. Instead, Congress sought to ensure that where federal statutory provisions or federal regulations expressly prescribe the duties of insurers and other entities participating in the Medicare Advantage or Medicare Part D prescription drug programs, those standards would supersede duplicative or inconsistent state-law standards and obligations.

To effectuate this intent, courts should take a careful, case-by-case approach to determine whether a plaintiff's state-law claims are preempted by federal Medicare rules, asking whether the particular state-law duty sought to be enforced would supplant a specific federal MA standard. Yet the parties' briefing and decision below make broad, bright-line statements, such as

"negligence, elder abuse, and wrongful death cases are based on California law in an area in which Medicare Part C regulations have established standards for MA plans." (Opn. 5.) Such a categorical approach is inconsistent with the text and purpose of the MA preemption provision and would improperly displace a wide range of state laws. This is not what Congress intended.

ARGUMENT

I. THE STATE HAS SUBSTANTIAL INTERESTS IN PROTECTING MEDICARE BENEFICIARIES, INCLUDING THOSE ENROLLED IN MEDICARE PLANS

A. Millions of vulnerable Californians receive healthcare services through private Medicare plans

Medicare is the national health insurance program to which all Social Security recipients (who are all either over 65 years of age or permanently disabled) are eligible. It is the single largest payor of health benefits in the United States and the primary payor for healthcare for seniors and adults with disabilities, including 6.4 million Californians.[1] Because Medicare enrollees generally have greater healthcare needs than younger and non-disabled healthcare consumers, Medicare accounts for 20% of the nation's total healthcare spending, despite enrolling 15% of

[1] Kaiser Family Foundation, *State Health Facts: Total Number of Medicare Beneficiaries* (2020), <https://www.kff.org/medicare/state-indicator/total-medicare-beneficiaries/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (as of June 6, 2022).

population.[2] The majority of Medicare beneficiaries are enrolled in the traditional, fee-for-service program established in 1965 by Part A of the Medicare Act (which provides inpatient, hospital benefits) and Part B (which covers outpatient benefits). The Centers for Medicare and Medicaid Services (CMS), an agency within the U.S. Department of Health and Human Services, is responsible for administering the Medicare program.

Medicare Advantage is a newer alternative to the fee-for-service model in Parts A and B. It began as a small experiment in capitated payment models in 1982 (see Tax Equity and Fiscal Responsibility Act, Pub.L. No. 97-248), but now enrolls 39% of all Medicare participants, more than 24 million people nationwide.[3] Formerly known as Medicare+Choice, Congress created "Medicare Advantage" as part of the Medicare Prescription Drug, Improvement, and Modernization Act of 2003 (hereinafter Medicare Modernization Act). (Pub.L. No. 108–173 (Dec. 8, 2003)

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[2] Centers for Medicare & Medicaid Services, *National Health Expenditure Data: Fact Sheet* (2020) <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet> (as of June 6, 2022).

[3] See generally The Commonwealth Fund, *The Evolution of Private Plans in Medicare* (Dec. 8, 2017) <https://www.commonwealthfund.org/publications/issue-briefs/2017/dec/evolution-private-plans-medicare> (as of June 6, 2022); Meredith Freed, Anthony Damico & Tricia Neuman, Kaiser Family Foundation, *A Dozen Facts About Medicare Advantage* (Jan. 13, 2021) < https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2020/> (as of June 6, 2022).

117 Stat. 2066.) That law also created Part D, which provides all Medicare enrollees the opportunity to enroll in standardized prescription drug coverage. (42 U.S.C. §§ 1395w-101 *et seq*.) MA plans provide for the delivery of benefits through private insurance organizations, in contrast to the traditional, fee-for-service structure of original Medicare. (42 U.S.C. § 1395w-21(a).) Insurance companies contract with the federal government to offer MA and Part D prescription drug plans in exchange for monthly fees from Medicare. (42 U.S.C. §§ 1395w-21, 23, & 24.)

California is one of the states with the highest proportion of MA enrollment, with over 45 percent of Medicare enrollees in some sort of MA plan for coverage of hospital and outpatient healthcare services, or more than 2.8 million people.[4] The Medicare Part D prescription drug program is even larger: over 5.1 million Medicare beneficiaries in California are enrolled in a Part D plan, either a stand-alone drug plans or an MA plan that offers prescription drug benefits.[5]

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[4] Meredith Freed *et al.*, Kaiser Family Foundation, *Medicare Advantage in 2021: Enrollment Update and Key Trends* (June 21, 2021) < https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/> (as of June 6, 2022).

[5] Kaiser Family Foundation, *State Health Facts: Medicare Beneficiaries Enrolled in Part D Coverage* <https://www.kff.org/other/state-indicator/medicare-beneficiaries-enrolled-in-part-d-coverage/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D> (as of June 6, 2022).

B. California law provides important protections for healthcare consumers, including Medicare enrollees

To protect all California residents, the state Legislature has adopted a range of laws that apply to insurers, medical professionals, and others connected with the delivery of healthcare services to California patients—including patients whose care is paid for by Medicare. For example, the 1991 Elder Abuse and Dependent Adult Civil Protection Act (hereinafter the Elder Abuse Act) (Welf. & Inst. Code §§ 15600 *et seq.*), one of the claims brought by Plaintiff in this case, protects "a particularly vulnerable portion of the population from gross mistreatment in the form of abuse and custodial neglect." (*Jarman v. HCR ManorCare, Inc.* (2020) 10 Cal.5th 375, 381 quoting *Delaney v. Baker* (1999) 20 Cal.4th 23, 33.) The Elder Abuse Act is enforced by both private parties and the State. For example, California's Department of Managed Health Care has investigated insurance brokers who fraudulently enrolled senior citizens into MA plans, a practice deemed to be a violation of the Elder Abuse Act.[6] Any entity, including an MA organization, that intentionally assisted a broker who committed such abusive conduct could be potentially liable under the Elder Abuse Act as well. (See Welf. & Inst. Code, § 15610.30, subd. (a)(2) [liability for those who assist with financial elder abuse].)

[6] Kelly Johnson, *Folsom Agent Barred from Selling Medicare Advantage*, Sacramento Business Journal (July 14, 2010) <https://www.bizjournals.com/sacramento/stories/2010/07/12/daily29.html> (as of June 6, 2022).

Many state laws protect skilled nursing facility residents, including California's Long-Term Care, Health, Safety, and Security Act of 1973 (Health & Saf. Code, § 1417 *et seq.*); the Patients' Bill of Rights (Health & Saf. Code § 1430, subd. (b)); and the Elder Abuse Act. The Patients' Bill of Rights, in particular, sets forth "fundamental human rights" that apply to nursing home residents in California. (See *Jarman, supra*, 10 Cal.5th 375 at p. 471.) These state health and safety laws protect Californians regardless of the source of their medical insurance, including enrollment in an MA plan or the traditional, fee-for-service Medicare program. (See Health & Saf. Code, § 1430, subd. (b)(1) [all current or former residents have right to bring civil action].)

State civil rights laws also protect patients, including Medicare beneficiaries. For example, the Unruh Act (Civil Code sections 51 *et seq.*) requires businesses to provide individuals "full and equal accommodations, advantages, facilities, privileges or services," including in the provision of medical services. (See *North Coast Women's Care Medical Group, Inc. v. San Diego County Superior Court* (2008) 44 Cal.4th 1145, 1153 [Unruh Act furthers California's compelling interest in ensuring full and equal access to medical treatment irrespective of sexual orientation].) And any entity that receives financial assistance from the State (which most healthcare providers do) has separate obligations under Government Code, section 11135, which prohibits discrimination or the denial of "full and equal access to the benefits" on the basis of "sex, race, color, religion, ancestry,

national origin, ethnic group identification, age, mental disability, physical disability, medical condition, genetic information, marital status, or sexual orientation."

As another example, California's Unfair Competition Law proscribes "any unlawful, unfair or fraudulent business act or practice," and specifically forbids "unfair, deceptive, untrue or misleading advertising." (Bus. & Prof. Code, § 17200.) This law applies to entities participating in or serving beneficiaries of the California Medicare program. (*McCall v. Pacificare, Inc.*, (2001) 25 Cal.4th 412, 426.) Recently, the California Attorney General, with a coalition of district and city attorneys, filed a lawsuit in Kern County against Brookdale Senior Living Inc., the nation's largest senior living operator, alleging that Brookdale violated state consumer protection and false advertising laws at its ten current and former California skilled nursing facilities for failing to comply with resident discharge notice requirements and reporting false staffing and patient quality measures information to attract more residents.[7] The parties' settlement benefits traditional Medicare and MA plan enrollees alike.[8]

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[7] *Attorney General Becerra Sues Nursing Home Chain for Misrepresenting its Quality of Care and Putting Seniors, People with Disabilities at Risk* (March 5, 2021) <https://oag.ca.gov/news/press-releases/attorney-general-becerra-sues-nursing-home-chain-misrepresenting-its-quality> (as of June 6, 2022).

[8] *Attorney General Bonta Announces $3.25 Million Settlement with Brookdale Senior Living for Misrepresenting Quality of Care and Putting Seniors, People with Disabilities at Risk* (March 11, 2022) <https://oag.ca.gov/news/press-

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Other state regulatory and law enforcement entities play an active role in the oversight and monitoring of Medicare plan activities. For example, the California Department of Managed Health Care (DMHC) monitors health plan networks and delivery systems, including MA plans. As part of its licensing responsibilities, DMHC reviews issues such as a plan's finances, organization, and history of compliance with applicable federal and state laws.[9] Medical professionals are subject to oversight by state healthcare oversight agencies, such as the Medical Board of California, which protects healthcare consumers through licensing and regulations of physicians and surgeons and enforcement of the Medical Practice Act. (See Bus. & Prof Code, §§ 2000 *et seq.*). When necessary, the Attorney General's Office brings both administrative and trial proceedings against state-licensed physicians and other health-related licensees. Through the California Department of Public Health (CDPH), the state also serves as "the primary enforcer of standards of care in the long-term health care facilities of this state." (*California Ass'n of*

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releases/attorney-general-bonta-announces-325-million-settlement-brookdale-senior-living> (as of June 6, 2022).

[9] California DMHC, *Medicare Advantage and Prescription Drug Plan New License Application Checklist* (version dated Jan. Jan. 28, 2021) <https://www.dmhc.ca.gov/Portals/0/Docs/OPL/Checklist%20for%20New%20License%20Application%20Medicare%20Advantage%20and%20Medicare%20Prescription%20Drug%20Plans%20Only%20(1_25_2021).pdf?ver=hawRwXKvlcSGM01O5ruf_g%3d%3d> (as of June 6, 2022).

Health Facilities v. Dept. of Health Servs. (1997) 16 Cal.4th 284, 305, fn. 7; see *Kizer v. County of San Mateo* (1991) 53 Cal.3d 139, 142.) The Attorney General's Division of Medi-Cal Fraud and Elder Abuse (DMFEA) investigates and prosecutes actions for patient abuse or neglect, including against nursing home providers, some of which may have contracts or subcontracts with MA organizations.[10]

The State is particularly involved with MA plans that serve individuals eligible for both Medicare and Medi-Cal, California's Medicaid program (also known as "dual eligibles"), who represent more than one-fifth of California Medicare beneficiaries.[11] The California Department of Health Care Services (DHCS) enters into three-way contracts with the federal government and insurers for all Dual Special Needs Plans, a type of MA plan that provides specialized care to dual eligibles.[12] DHCS works closely with these types of plans to achieve state policy goals such as

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[10] Division of Medi-Cal Fraud and Elder Abuse, <https://oag.ca.gov/dmfea> (as of June 6, 2022).

[11] DHCS, *Profile of the California Medicare Population* (Feb. 18, 2022) <https://www.dhcs.ca.gov/services/Documents/OMII-Medicare-Databook-February-18-2022.pdf> (as of June 6, 2022).

[12] DHCS, *CalAIM Dual Eligible Special Needs Plans Policy Guide* (Dec. 2021), <https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Special-Needs-Plans-%28D-SNP%29-Contract-and-Program-Guide.aspx#:~:text=Dual%20Special%20Needs%20Plans%20%28D-SNPs%29%20are%20Medicare%20Advantage,Health%20Care%20Services%20%28DHCS%29%2C%20the%20state%20Medicaid%20agency.?msclkid=99725bf6d0a911ec821cf391ca9837bd> (as of June 6, 2022).

improved care integration and person-centered care.[13] When necessary, law enforcement agencies work together to ensure that these types of MA plans adhere to state and federal duties.[14]

II. EXPRESS PREEMPTION APPLIES ONLY WHERE STATE LAWS WOULD SUPPLANT FEDERAL MEDICARE ADVANTAGE STANDARDS

The Medicare Modernization Act does not categorically preempt the application of these and other important state protections when they are applied to an MA plan. Instead, the MA preemption provision expressly displaces state authority only to the extent that particular federal MA standards govern specific conduct that would otherwise be subject to contrary or duplicative state standards.

A. Relevant legal standards and statutory background

"Express preemption occurs when Congress defines the extent to which its enactments preempt state law." (*People ex rel. Harris v. Pac Anchor Transportation, Inc.* (2014) 59 Cal.4th 772, 777.) Congress's objectives are "a guide to the scope of the state

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[13] DHCS, *Dual Eligible Special Needs Plans in California* (last modified Jan. 5, 2022), <https://www.dhcs.ca.gov/provgovpart/Pages/Dual-Eligible-Special-Needs-Plans-in-CA.aspx> (as of June 6, 2022).

[14] See, e.g., *Attorney General Kamala D. Harris Announces Largest Medi-Cal Settlement in California History* (Aug. 23, 2012) <https://oag.ca.gov/news/press-releases/attorney-general-kamala-d-harris-announces-largest-medi-cal-settlement> (as of June 6, 2022) [describing $323 million joint settlement with the California Attorney General and the U.S. Department of Justice against MA plan].

law that Congress understood would survive." (*Rutledge v. Pharmaceutical Care Mgmt. Ass'n* (2020) 141 S.Ct. 474, 480, quoting *California Div. of Labor Standards Enforcement v. Dillingham Constr., N. A., Inc.* (1997) 519 U.S. 316, 325.)

As an initial matter, California notes that the universe of state-law claims subject to section 1395w-26(b)(3) is limited because Congress has placed antecedent jurisdictional limitations on all claims that "arise under" the Medicare Act. (See *McCall, supra,* 25 Cal.4th at pp. 416-417; and 42 U.S.C. §§ 405(g), (h) [judicial review only available after final agency decision and exhaustion of federal administrative remedies], 1395ii, 1395ff(b)(1), 1395mm(c)(5)(B)).) The administrative review scheme for disputes arising under the Medicare Advantage program is "modeled on the administrative review scheme Congress established under original Medicare." (*Global Rescue Jets, LLC v. Kaiser Found. Health Plan, Inc.*, (9th Cir. 2022) 30 F.4th 905, 9011.) Well-established case law provides that a claim "arises under" the Medicare Act if it is "inextricably intertwined" with a claim for Medicare benefits, meaning that it "necessarily implicate[s] coverage determinations or fall[s] within the scope of the Medicare Act review process." (*McCall, supra,* 25 Cal.4th at pp. 425-26, citing *Heckler v. Ringer* (1984) 466 U.S. 602, 417, 426.) Courts examine pleadings for claims brought under either state consumer protection statutes or state common law to determine whether they are actually artfully pleaded claims

arising under the Medicare Act.[15] Although "arising under" and preemption inquiries often overlap, preemption only becomes pertinent where there is no jurisdictional bar. (See, e.g., *Uhm*, *supra*, 620 F.3d at pp. 1145-48.)

Congress enacted the current express preemption provision applicable to the MA and Medicare Part D programs in 2003 in a section of the Medicare Modernization Act titled "Avoiding duplicative State regulation." (Pub.L. No. 108–173 (Dec. 8, 2003) 117 Stat. 2066, section 232.) That provision revised Part C's prior preemption provision, which had applied to state laws within four specific enumerated categories if those state standards were "inconsistent" with federal Medicare law. ((2000) 42 U.S.C. § 1395w-26(b)(3)(A).) The amended provision states:

> the standards established under this part shall supersede any State law or regulation (other than State

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[15] See, e.g., *Do Sung Uhm v. Humana, Inc.* (9th Cir. 2010) 620 F.3d 1134, 1141-48 [affirming dismissal of Washington state consumer protection and common law claims after a "careful review" of the plaintiffs' state law claims for breach of contract and unjust enrichment]; *Kaiser v. Blue Cross* (9th Cir. 2003) 347 F.3d 1107, 1112 [courts consider claims to be "inextricably intertwined" with the Medicare Act when they are "cleverly concealed claims for benefits"]; *Phillips v. Kaiser Foundation Health Plan, Inc.*, (N.D. Cal. 2011) 953 F.Supp.2d 1078, 1089-90 [relying on *Uhm* and concluding that it "does not matter" that plaintiff relied on California consumer protection laws because her claims were a "disguised claim for [Medicare] benefits"]; *cf. RenCare, Ltd. v. Humana Health Plan of Texas, Inc.* (5th Cir. 2004) 395 F.3d 555, 558 [claim by provider against MA plan did not "arise under" Medicare Act because services were already provided and dispute could not be remedied by Medicare administrative procedures].)

> licensing laws or State laws relating to plan solvency) with respect to MA plans which are offered by MA organizations under this part.

((2003) 42 U.S.C. § 1395w-26(b)(3).) In other words, Congress broadened the scope of MA preemption to supersede even state laws or regulations not in direct conflict with federal law, and to eliminate the previous four enumerated categories of preempted state laws. (See *Uhm, supra,* 620 F.3d at pp. 1149–50 [concluding that Congress intended to "broaden the preemptive effects of the Medicare statutory regime […] beyond those state laws and regulations inconsistent with the [pre-2003] enumerated standards"].) This same preemption provision also applies to Medicare Part D prescription drug plans. (42 U.S.C. § 1395w-112(g).)

B. Congress attached preemption only to specific federal legal standards

Although Congress broadened MA preemption, the preemptive scope of section 1395w-26(b)(3) is not unlimited. First, the text makes clear that only "standards established under this part" (i.e., Part C, and for prescription drug plans, Part D) have been expressly endowed by Congress with preemptive effect. (See *Pharmaceutical Care Management Ass'n v. Wehbi* (8th Cir. 2021) 18 F.4th 956, 971 (standards mean "statutory provision[s] or regulation[s] promulgated under" Parts C or D and "published in the Code of Federal Regulations" (citations omitted).) All of the specific standards Congress set forth under Part C relate directly to the operation of the new federal benefit program, including areas such as beneficiaries'

eligibility, election, and enrollment into MA plans (42 U.S.C. § 1395w-21); beneficiary protections such as minimum benefits, prohibitions against discrimination in plan design or provider participation, disclosure requirements, accessibility requirements, and grievance and appeal procedures (42 U.S.C. § 1395w-22); and rules regarding MA financing and contracts (42 U.S.C. §§ 1395w-23-27).

Congress also authorized CMS to establish further standards for MA organization solvency as well as "other standards […] consistent with, and to carry out, this part." (42 U.S.C. § 1395w-26(b)(1).) CMS has exercised that authority by promulgating comprehensive regulations detailing MA plans' federal obligations. (See generally 42 C.F.R., Part 422.) For the most part, these regulations are specifically directed toward MA organizations and the MA plans that they offer, although in some places the regulations refer to specific obligations of "first tier entities" or "downstream entities" which are contracted to offer health care or administrative services. (See 42 C.F.R. § 422.2 [defining first tier and downstream entities].) CMS regulations specify operational details ranging from the basic health benefits that all MA plans must offer (42 C.F.R. § 422.101); minimum distances for each provider specialty in the MA plan's network (42 C.F.R. § 422.116); impermissible factors that MA organizations may not use to deny, limit, or condition coverage (42 C.F.R. § 110); and many more.

In specifying that only "standards established under this part shall supersede" certain state laws, the preemption

provision does not limit areas where neither Congress nor CMS has promulgated a specific statutory provision or regulation under Part C or D. This leaves many state health and welfare laws, or other laws of general applicability, that could properly be applied to an MA plan or contractor.

Judicial inquiries into state law claims against an MA plan or related entity accordingly should seek to determine whether the state law duties to be enforced are already prescribed by specific federal standards. For both subject matter jurisdiction and preemption questions, this involves careful comparison of the substance of state-law claims and related allegations with CMS's detailed federal standards for private Medicare plans before deciding whether a particular state claim arises under the Medicare Act or is preempted by section 1394w-26(b)(3). The plain language of the current MA preemption provision requires a court to "identify whether there is a relevant standard established under Part C with preemptive effect," because "generally applicable state consumer protection laws and common law claims *can* fall within the ambit of Part C's preemption provision." (*Aylward v. SelectHealth, Inc.* (9th Cir. 2022) 31 F.4th 719, 726, 727.) In that recent decision, the Ninth Circuit analyzed the plaintiff's allegations underlying various state tort claims, finding that they sought to impose on MA plans specific state law duties regarding timeliness and appeal rights that were preempted by specific Part C federal regulations which "expressly prescribe the relevant duties of MA plans with respect to when expedited treatment is required and what timeframes

apply." (*Id.* at 728.) Similar conclusions support other limited preemption holdings. (See *Yarick v. PacifiCare of California* (2009) 179 Cal.App.4th 1158, 1166 [holding that "the federal statute expressly preempts application of state laws where "standards" for MA plans are established pursuant to the Medicare law"]; *Uhm*, *supra*, 620 F.3d at pp. 1150-57 [finding state fraud and consumer protection claims preempted under prior preemption provision "by the extensive CMS regulations governing [Medicare Part D] marketing materials"]; *Dial v. Healthspring of Alabama, Inc.* (S.D. Ala. 2007) 501 F.Supp.2d 1348, rev'd on other grounds, (11th Cir. 2008) 541 F.3d 1044 [finding that the legislative history and Congressional intent of section 1394w-26(b)(3) "was intended to preempt state law applicable to areas for which the [Medicare Modernization Act] has established regulations or standards"]; *Morrison v. Health Plan of Nevada, Inc.*, (Nev. Sup. Ct. 2014) 130 Nev. 517, 523-25 [holding state negligence claim preempted by MA provider selection and contracting standards].)

The decision below fails to engage in this level of analysis, and its conclusion could be read to suggest that Medicare Part C standards preempt all state laws and regulations categorically. (See Opn. 9.) The decision below also fails to differentiate in its preemption analysis the respective federal duties that apply to the MA plan and its sponsors (UnitedHealthcare and related entities) versus the contracted provider organization (Healthcare Partners and related entities). It is not clear whether Healthcare Partners are first-tier entities or downstream entities, or which

specific portion of UnitedHealthcare's responsibilities as an MA organization have been delegated. (Cf. 42 C.F.R. § 422.2.) To simply state, as Defendants do, that the federal obligations on downstream entities "are largely […] the same" (ABM 42, fn. 1) is not sufficient for purposes of determining whether section 1394w-26(b)(3)'s express preemption applies to the claims against the provider entities. According to the specific regulation that Defendants cite, "the MA organization maintains ultimate responsibility for adhering to and otherwise fully complying with all terms and conditions of its contract with CMS" (42 C.F.R. § 422.504(i)(1)), and first tier, downstream, and related entities must have contracts that "specify delegated activities and reporting responsibilities." (42 C.F.R. § 422.504(i)(4)(i)). The court below should have considered the extent to which applicable federal standards govern the obligations of specific types of Defendants in this case.

C. Congress' preemption of state laws "with respect to" MA plans does not encompass all state standards that may be applied to MA plans

In addition to restricting MA preemption to conduct governed by specific federal standards established under Part C, Section 1395w-26(b)(3) placed another meaningful limit on preemption by stating that only state laws "with respect to MA plans" are superseded.

Aspects of the Medicare Modernization Act and the larger Medicare Act that acknowledge an ongoing role for state law confirm that Congress did not intend to categorically preempt all

state laws or otherwise engage in field preemption. Congress envisioned a significant role for state oversight of MA and Part D plans by explicitly exempting State licensing and plan solvency laws. (42 U.S.C. § 1395w-26(b)(3).) And when expanding the MA preemption provision, Congress did not disturb the Medicare Act's prohibition against federal interference in the practice of medicine, which forbids "any Federal officer or employee" to authorize "any supervision or control over the practice of medicine and the manner in which medical services are delivered to Medicare beneficiaries." (42 U.S.C. § 1395.)

To be sure, Congress did intend to broaden MA preemption beyond its previous scope. But the available legislative history suggests that Congress was simply concerned that federal programs operate according to federal rules (except for state plan licensing and solvency requirements). The House of Representative's very brief reference to the preemption provision in the 2003 Conference Report (two short paragraphs in an 852-page document) confirms that Congress was concerned with the federal nature of the MA and prescription drug programs, but does not suggest that Congress ever considered, much less intended, the undoing of all traditional state law health and safety or generally applicable duties and obligations that could possibly apply to Medicare Part C or D plans or their contractors. (See H.R. Rep. No. 108-391, 1st Sess., p. 557 (2003).)

The federal Medicare agency's interpretation of section 1395w-26(b)(3) makes clear the agency's view that significant categories of state jurisdiction remain applicable to MA and Part

D plans. In its 2005 final rulemaking about the MA program, CMS explained its view that federal preemption can apply to state standards or duties derived from common law, but also affirmed that "State health and safety standards, or generally applicable standards, *that do not involve regulation of an MA plan* are not preempted." (*Establishment of the Medicare Advantage Program* 70 Fed. Reg. 4588, at p. 4665 (Jan. 28, 2005) (emphasis added).) In concurrent Medicare Part D regulations construing the same preemption provision, CMS rejected a request from an insurer for a broad statement that "all State laws and regulations (with the exception of State licensing and solvency laws) are preempted," explaining instead,

> we do not believe that either the principles of Federalism or the statute justify such a broad preemption interpretation. We do not believe, for example, we could preempt all State environmental or civil rights laws, nor do we believe it was the Congress' intent to do so. The preemption in section 1860D–12(g) of the Act is a preemption that operates only *when CMS actually creates standards in the area regulated*. To the extent we do not create any standards whatsoever in a particular area, we do not believe preemption would be warranted.

(*Medicare Prescription Drug Benefit* 70 Fed. Reg. 4194, at pp. 4319-20 (Jan. 28, 2005) (emphasis added).) Subsequent CMS guidance reiterates this point, noting that although "State laws and regulations that regulate health plans do not apply to MA plans offered by MA organizations," "State health and safety standards, or generally applicable standards, that are not specific to health plans, are not preempted." (Medicare Managed Care Manual (MMCM) §§ 30.1, 30.2 (last revised Nov. 4, 2011),

<https://www.cms.gov/Regulations-and-Guidance/Guidance/Manuals/downloads/mc86c10.pdf> (as of June 7, 2022).) CMS promises to address "specific preemption questions in cooperation with States on a case-by-case basis." (*Ibid.*)

As the U.S. Supreme Court has observed in connection with similar language in the Employee Retirement Income Security Act (ERISA), 29 U.S.C. §§ 1001 *et seq*., "'if 'relate to' were taken to extend to the furthest stretch of its indeterminacy, then for all practical purposes preemption would never run its course.'" (*Gobeille v. Liberty Mut. Ins. Co.* (2016) 136 S.Ct. 936, 943, quoting *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 655).) In their answer brief, however, Defendants suggest that section 1395w-26(b)(3)'s "with respect to" clause should be construed to mean that federal standards preempt all generally applicable state laws "as applied to MA plans." (ABM 48; see also ABM 50 ["At the very least, Quishenberry's claims touch on the administration of MA plans"].) The only specific limit Defendants acknowledge "with respect to" contains are when state laws apply to "other health insurance plans offered by MA organizations."[16] (*Id.* at pp. 48-49.)

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[16] Exactly what Defendants mean by "other health insurance plans offered by MA organizations" is unclear. While an MA organization may choose to offer a number of different health insurance plans, an MA organization is by definition an "entity organized and licensed by a State as a risk-bearing entity (with the exception of provider-sponsored organizations receiving

(continued…)

Because "[t]hat is a result no sensible person could have intended," the U.S. Supreme Court has developed "workable standards" that "reject 'uncritical literalism' in applying" ERISA's preemption clause. (*Gobeille*, *supra*, 136 S.Ct. at p. 943 (internal quotation marks omitted).) These standards seek to "avoid[] the clause's susceptibility to limitless application." (*Ibid.*) As a result, the Court has held, "not every state law that affects an ERISA plan or causes some disuniformity in plan administration has an impermissible connection with an ERISA plan." (*Rutledge v. Pharmaceutical Care Management Ass'n*, *supra*, 141 S.Ct. at p. 480.)

The same limiting principles hold true in the Medicare context: just because a state law may have some fiscal impact on an MA or Part D plan, or creates some state-by-state variation in plan administration, does not mean that the state law is "with respect to" an MA plan in the manner that Congress has

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(…continued)

waivers) that is certified by CMS as meeting the MA contract requirements." (42 C.F.R. § 422.2.) MA organizations are subject to state licensure requirement and some of their plan offerings may be subject to state Medicaid requirements (see *First Med. Health Plan, Inc. v. Vega–Ramos*, (1st Cir. 2007) 479 F.3d 46, 52), as well as other generally applicable state laws. That does not make the MA organization's plan offerings something other than an "MA plan." (See CMS, Dual Eligible Special Needs Plans (last modified Dec. 1, 2021) <https://www.cms.gov/Medicare/Health-Plans/SpecialNeedsPlans/D-SNPs> [as of June 6, 2022]; 42 C.F.R. § 422.2 [defining "Specialized MA Plans for Special Needs Individuals" as an "MA coordinated care plan" that *inter alia* provides Part D benefits].)

expressly preempted. As the U.S. Supreme Court has repeatedly observed, "'myriad state laws' of general applicability . . . impose some burdens on the administration of […] plans but nevertheless do not 'relate to' them within the meaning of the governing statute." (*De Buono v. NYSA-ILA Medical and Clinical Servs. Fund* (1997) 520 U.S. 806, 815.) "Congress could not possibly have intended to eliminate" such a broad swath of state laws. (*N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.*, 514 U.S. at p. 668; see *id.* at p. 661 (noting other types of "common state actions with indirect economic effects on a plan[]").) State health and welfare laws, and other laws of general applicability like those involving California's civil rights protections, workers' rights protections, or environmental laws, may increase the costs of doing business for MA plans, or alter their incentives in a way that change their behavior. But as long as those state law duties do not supplant federally prescribed standards governing the plan's conduct, they are not preempted. (See, e.g., *Rutledge v. Pharmaceutical Care Mgmt. Ass'n, supra*, 141 S.Ct. at 480 [ERISA does not preempt state rate regulations that increase costs or alter incentives for plans if plans are not forced to adopt a "particular scheme of substantive coverage"]; *California Trucking Ass'n v. Bonta* (9th Cir. 2021) 996 F.3d 644, 647, petn. cert. filed Aug. 11, 2021 (No. 21-194) [laws of general applicability are not "related to" federal law even if they may change the relationship of employers with their work force, raise the cost of doing business, or shift incentives in a way that

changes an organization's business decisions], citing *Dilts v. Penske Logistics, LLC* (9th Cir. 2014) 769 F.3d 637, 646-47.)

The Court of Appeal characterized the "majority of courts'" as "interpret[ing] [the federal statute] to displace state laws to the extent they touch upon areas regulated by Medicare Advantage standards." (*Roberts v. United Healthcare Servs.* (2016) 2 Cal.App.5th 132, 144; Opn. 8-9 (following *Roberts*).) But that observation does not account for the extent to which the holdings in these cases—as well as the claims brought in *Uhm* and other similar caselaw upon which the court relied—were shaped by allegations that did not merely "touch on" federal MA plan standards, but in fact involved the plaintiffs' efforts to enforce federal rules, or to enforce state standards covering areas where federal laws and regulations directly prescribe a defendant's conduct, or even were so inextricably intertwined with individual claims for Medicare benefits that could have been remedied in federal administrative review schedule. (See, e.g., Opn. 6 [plaintiffs' allegations "require a determination of the amount of allowable Medicare benefits for skilled nursing care, an area regulated by standards established by CMS"]; *Uhm*, *supra*, 620 F.3d at p. 1143 [plaintiffs' allegations were "at bottom, merely creatively disguised claims for [Medicare] benefits," with no underlying violation of a duty or law beyond the requirements of the Medicare Act itself, and could have been remedied through the Medicare administrative review process].)

The briefing here and the opinion below focus in part on the question of whether preemption applies only to positive state

enactments or those established by common law. This is not, however, the central question. Courts look at the substance of specific state claims against MA plans, including those grounded in state common law, before making a determination as to whether they arise under the Medicare Act or are otherwise expressly preempted by section 1394w-26(b)(3) and applicable federal standards. (See *Yarick v. PacifiCare of California, supra*, 179 Cal.App.4th at p. 1168 ["While *all* common law claims against MA organizations are not preempted merely because of the organization's MA status, *these* causes of action for breach of state statutory duties are preempted."] (emphasis in original).) But the fact that specific state common law claims *may* be preempted does not mean that Congress intended to displace *all* state law claims as applied to MA plans.

III. STATE HEALTH AND SAFETY STANDARDS AND OTHER LAWS OF GENERAL APPLICABILITY DO NOT GENERALLY PRESENT AN OBSTACLE TO FEDERAL LAW

The Court should also refrain from an overbroad ruling on the second question presented in the petition: whether Plaintiff's claims for negligence, elder abuse, and wrongful death are preempted based on the doctrine of "obstacle preemption." MA and Part D plans' and contractors' adherence to the same state statutes, standards, and duties that apply to any insurance plan, medical facility, medical professional, or public-serving business, supports Congress's objective of providing healthcare benefits to older adults and people with disabilities.

"Obstacle preemption occurs when state law stands as an obstacle to the full accomplishment and execution of

congressional objectives." (*People ex rel. Harris v. Pac Anchor Transportation, supra,* 59 Cal.4th at p. 778.) In the absence of "clear and manifest purpose of Congress," "courts should assume that 'the historic police powers of the States' are not superseded.'" (*Arizona v. U.S.* (2012) 567 U.S. 387, 400, citing *Wyeth v. Levine* 555 U.S. 555, 565); *Cal. Div. of Labor Standards Enforcement v. Dillingham Constr., N.A., Inc.* (1997) 519 U.S. 316, 325.) "This presumption applies to the scope as well as the existence of preemption." (*Solus Indus. Innovations, LLC, v. Superior Court* (2018) 4 Cal.5th 316.) Here, this presumption "is consistent with both federalism concerns and the historic primacy of state regulation of matters of health and safety." (*Medtronic, Inc., v. Lohr* (1996) 518 U.S. 470, 485; see also *N.Y. State Conf. of Blue Cross & Blue Shield Plans v. Travelers Ins. Co.* (1995) 514 U.S. 645, 661; 70 Fed. Reg. at 4319-20.) And as the U.S. Supreme Court has warned, courts should not engage in a "freewheeling judicial inquiry into whether a state statute is in tension with federal objectives." (*Chamber of Commerce v. Whiting* (2011) 563 U.S. 582, 607 (plurality), quoting *Gade v. Nat'l Solid Wastes Mgmt. Ass'n*, (1992) 505 U.S. 88, 111); accord *Kansas v. Garcia*, (2020) 140 S.Ct. 791, 801.)

Outside of the types of cases noted in Section II that are subject to either the Medicare Act's "arising under" jurisprudence or the MA express preemption provision, and in the absence of actual conflict between state and federal laws, the Court should presume that enforcement of generally applicable state laws against private Medicare plans is appropriate. Generally

speaking, state statutes and common law duties—such as duties of care, duties of good faith and fair dealing in contracts, requirements to treat the public fairly, honestly, and without discrimination, and special duties owed to vulnerable older adults and people with disabilities under the Elder Abuse Act—complement rather than obstruct Congress' purpose in the Medicare Modernization Act. This statute sought to expand and improve access to healthcare by creating a new prescription drug benefit and strengthening and improving the Medicare program. (See Pub.L. No. 108-173 (2003) [purpose of law "to provide for a voluntary program for prescription drug coverage under the Medicare Program, to modernize the Medicare Program"].) Using preemption to bar all state consumer protections for seniors and people with disabilities would undercut Congress' intent "to promote an active, informed selection" of plans by Medicare beneficiaries and to evaluate "quality and performance" of those plans based on enrollee satisfaction and health outcomes. (42 U.S.C. §§ 1395w-21(d)(1), (d)(4)(D).) Indeed, state efforts to protect against fraud or discrimination in the MA program complement federal standards of fair access and freedom of choice. And CMS has generally concluded that general health care and safety regulations and other generally applicable state laws do not interfere with federal administration of the MA program. (See 70 Fed. Reg. at pp. 4319-20 and 70 Fed. Reg. at p. 4665.)

The federal interests that Defendants identify do not justify an implied preemption holding. Defendants invoke the specter of

state juries revisiting Medicare coverage determinations; a state court undoing MA capitated payment models; or beneficiaries deliberately waiting until federal administrative remedies were unavailable in order to seek damages in state court. (ABM 62-63.) But these scenarios may be governed by express federal laws and regulations (making duplicative state claims preempted) as well as potentially subject to the Medicare Act's jurisdictional requirements (42 U.S.C. §§ 405(g), (h)). As explained in Section II above, Congress expressly preempted state laws with respect to Medicare plans in those areas where CMS has established Part C and D regulations, and *Heckler v. Ringer* requires that courts consider as a jurisdictional matter whether artful pleading of state law claims disguises claims that "at bottom" arise under the Medicare Act. Courts need not resort to an implied preemption doctrine in order to avoid adjudicating those types of putative state law claims.

Furthermore, there is no "inevitable collision" between state-law duties that may apply to private Medicare plans, and Medicare's federal non-interference law. (Contra ABM 67.) The fact that federal Medicare rules cannot mandate particular medical practice standards is entirely consistent with state oversight agencies' responsibilities to establish such standards, and with insurers' and their contractors' related statutory or common law duties.

For state health and safety standards, and other generally applicable laws, the "pervasiveness of federal regulation does not diminish the importance" of these laws to the State. (*Arizona*,

supra, 567 U.S. at p. 397.) While the precise limits of MA preemption will vary depending on plaintiffs' particular claims, section 1394w-26(b)(3) does not categorically preempt health and safety and other generally applicable state laws. Private Medicare plans that violate generally applicable California laws, or breach their state-law duties to members of the public, their employees, or individuals who are elderly or dependent, should not be immune from state court liability unless a specific obstacle is identified and Congress' intent to impliedly displace the state law duty is clear and manifest.

CONCLUSION

The Court should hold that section 1394w-26(b)(3) does not categorically preempt state health and welfare laws, and other state laws of general applicability, but displaces state authorities only when they would otherwise supplant specific federal standards established under Medicare Part C or Part D.

Respectfully submitted,

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June 8, 2022

CERTIFICATE OF COMPLIANCE

I certify that the attached BRIEF FOR THE ATTORNEY GENERAL AS AMICUS CURIAE uses a 13 point Century Schoolbook font and contains 6,765 words.

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June 8, 2022

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