Nos. 24-3654, 24-3655, 24-3700

UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

FRESENIUS MEDICAL CARE ORANGE COUNTY, LLC, *et al.*,
Plaintiffs-Appellants,

and

JANE DOE, *et al.*,
Plaintiffs,

v.

ROB BONTA, in his Official Capacity as Attorney General of California, *et al.*,
Defendants-Appellees.

[CAPTIONS CONTINUED ON INSIDE COVER]

On Appeals from the United States District Court
for the Central District of California
Nos. 8:19-cv-02105 DOC (ADS) & 8:19-cv-02130 DOC (ADS) (Carter, J.)

OPENING BRIEF FOR PLAINTIFFS-APPELLANTS FRESENIUS MEDICAL CARE ORANGE COUNTY, LLC, FRESENIUS MEDICAL CARE HOLDINGS, INC. D/B/A FRESENIUS MEDICAL CARE NORTH AMERICA, DAVITA INC., AND U.S. RENAL CARE, INC.

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Plaintiffs-Appellants,

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RULE 26.1 STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1, Plaintiffs-Appellants state as follows:

Fresenius Medical Care Orange County, LLC is a joint venture owned by MemorialCare Medical Foundation; The OC Group, LLC; RAI Care Centers of Southern California I, LLC; and Bio-Medical Applications of California, Inc. RAI Care Centers of Southern California I, LLC's parent corporation is RAI Care Centers Holdings I, LLC; RAI Care Centers Holdings I, LLC's parent corporation is Renal Advantage, Inc.; Renal Advantage, Inc.'s parent corporation is Renal Advantage Holdings, Inc.; Renal Advantage Holdings, Inc.'s parent corporation is RA Acquisition Co., LLC; RA Acquisition Co., LLC's parent corporation is Renal Advantage Partners, LLC; Renal Advantage Partners, LLC is owned by BioMedical Applications Management Co., Inc. and Liberty Dialysis Holdings, Inc. (which is wholly owned by Bio-Medical Applications Management Co., Inc); BioMedical Applications Management Co., Inc.'s parent corporation is National Medical Care, Inc.; National Medical Care, Inc.'s parent corporation is Fresenius Medical Care Holdings, Inc.; Fresenius Medical Care Holdings, Inc.'s ultimate parent corporation is listed in the next paragraph. Bio-Medical Applications of California, Inc.'s parent is Bio-Medical Applications Management Co., Inc.; BioMedical Applications Management Co., Inc.'s parent corporation is National

Medical Care, Inc.; National Medical Care, Inc.'s parent corporation is Fresenius Medical Care Holdings, Inc.; Fresenius Medical Care Holdings, Inc.'s ultimate parent corporation is listed in the next paragraph; MemorialCare Medical Foundation is a California non-profit public benefit corporation. The OC Group, LLC, is a privately held company with no parent corporation.

Fresenius Medical Care Holdings, Inc. d/b/a Fresenius Medical Care North America ("FMCH"), is an indirect, wholly owned subsidiary of its ultimate parent company Fresenius Medical Care AG. Fresenius Medical Care AG is a German stock corporation whose stock is publicly traded on the Frankfurt Stock Exchange under the ticker symbol "FME" and whose American Depositary Receipts are traded on the New York Stock Exchange under the ticker symbol "FMS." Other than Fresenius Medical Care AG, none of FMCH's affiliates or subsidiaries are publicly traded.

DaVita Inc. is a publicly traded corporation owned by its shareholders. It has no parent company. Based on public filings as of August 6, 2024, Berkshire Hathaway Inc. owns 10% or more of its stock.

U.S. Renal Care, Inc. ("USRC") is a privately held company. USRC's parent corporation is Rangers Renal Intermediate, Inc.; Rangers Renal Intermediate, Inc.'s parent corporation is Rangers Renal Intermediate Holdings, Inc.; Rangers Renal Intermediate Holdings, Inc.'s parent corporation is BCPE

Cycle Buyer, Inc.; and BCPE Cycle Buyer, Inc.'s parent corporation is BCPE Cycle Holdings, L.P.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

Page(s)

STATUTES, RULES, AND REGULATIONS

OTHER AUTHORITIES

INTRODUCTION

This appeal concerns a California law that threatens the lifesaving, charitable work of the American Kidney Fund (AKF). It does so by imposing direct, punitive, and unconstitutional burdens on the First Amendment rights of those who contribute to AKF. AKF is a charitable organization that does essential work for patients who suffer from kidney failure. It advocates for patients at all levels of government. It educates patients and the public about kidney disease. And it provides charitable grants that thousands of low-income patients in California use to pay for vital healthcare coverage. AKF, in turn, depends on charitable contributions from tens of thousands of donors, including dialysis providers like plaintiffs-appellants who treat patients with end-stage renal disease (ESRD) and are among AKF's largest contributors.

Most of the patients who receive financial assistance from AKF use that assistance to obtain public health insurance. The rest choose private insurance because, for them, public options are unavailable or inadequate. Some patients are ineligible for public options because of their immigration status or work histories. Still others prefer private insurance because it lowers patients' costs for care, provides better coverage, or is associated with better health outcomes, including greater access to kidney transplants.

AKF's charitable program has effectively served patients for decades. But it has come under attack from private insurance companies who have long tried to push ESRD patients off of their books, and onto government programs, because ESRD patients are expensive patients to cover. These insurers oppose AKF's charitable grants because those grants help low-income ESRD patients afford private insurance (in addition to public insurance). The law at issue here—AB290—is the latest result of these efforts by insurers and their allies.

AB290 targets charities like AKF, and health care providers like plaintiffs-appellants, through a series of interlocking and unconstitutional provisions—two of which the district court correctly struck down. First, AB290's "Advising Restriction" bars healthcare providers from "steering" or "advising" patients about insurance plans. The district court determined that this provision violates providers' First Amendment rights to freely communicate with their patients. Second, AB290's "Patient Disclosure Mandate" requires AKF to disclose to insurance companies the names of the people who use its premium-assistance program. The court held that this provision likewise violates the First Amendment by interfering with AKF's right to associate with its patients, who may wish to maintain their privacy. The State has cross-appealed those rulings.

At issue in this appeal is AB290's third component—a "Reimbursement Penalty" that threatens to hobble AKF's vital charitable work by targeting the

healthcare providers that donate to AKF. When AKF's contributors treat a patient who uses AKF's assistance to obtain commercial coverage, the Penalty slashes reimbursement rates—which providers freely negotiated with insurers—bringing them down to a level that is often at or below the cost of providing care. In purpose and effect, this harsh penalty discourages providers from contributing to AKF, thereby threatening to defund AKF and jeopardizing the charitable support on which thousands of California's most vulnerable residents rely.

The Reimbursement Penalty is unconstitutional. As the Supreme Court recently affirmed in striking down another California law that penalized charitable contributors, the First Amendment tightly limits a state's ability to impose burdens on charitable contributions to an expressive organization such as AKF. *See Americans for Prosperity Foundation v. Bonta*, 594 U.S. 595, 618 (2021). The district court erred in refusing to apply that principle. The court treated the First Amendment as effectively inapplicable because health care providers can "gain financially" from their contributions, which the court therefore deemed "transaction[s]" involving *no* protected "express[ion]." *See* 1-ER-50.

That conclusion disregards both the undisputed facts and the law. No one disputes that providers benefit financially when patients obtain health care using AKF's assistance, and that they receive higher, negotiated reimbursement for those patients who select private rather than public health insurance. But the existence

of that financial benefit does not deprive providers' contributions of First Amendment protection. It is undisputed that the providers here also contribute to AKF to express support for and enable AKF's charitable, expressive mission, including its advocacy and education efforts. The Supreme Court and this Court repeatedly have held that the First Amendment does not disappear whenever speech or association has some economic benefits. Providers' contributions are speech and association protected by the First Amendment.

The State was utterly unable to justify the burden that the Reimbursement Penalty imposes on providers' First Amendment rights. AB290 purports to address concerns with patient "steering"—the notion that providers push patients into private insurance against the patient's best interests. In striking down AB290's other components, the district court found no evidence of any so-called patient "steering," nor any evidence of harm resulting from supposed steering. Indeed, despite years of litigation and extensive discovery, the State was forced to admit that it cannot identify even a *single* patient in California steered onto a different insurance plan, much less one harmed by such hypothetical steering. Furthermore, the court's decision upholding the Reimbursement Penalty also must be reversed because that provision, as the state conceded, cannot function without the Patient Disclosure Mandate that the district court struck down and thus is inseverable.

At bottom, the Reimbursement Penalty is a harsh solution in search of a problem. It penalizes providers' expressive and associational rights, and it threatens to deprive thousands of low-income ESRD patients of life-saving charitable support—all to address a concern the State has no evidence to support and only to the benefit of private insurers. The judgment should be reversed insofar as it held the Reimbursement Penalty constitutional, and the Penalty should be permanently enjoined.

JURISDICTION

The district court had subject matter jurisdiction under 28 U.S.C. § 1331 and 42 U.S.C. § 1983. This Court has jurisdiction over the district court's final judgment. 28 U.S.C. § 1291. The district court entered a Stipulated Final Judgment, Permanent Injunction, and Stay Pending Appeal on May 9, 2024. Plaintiff-appellants timely filed a notice of appeal on June 7, 2024. Fed. R. App. P. 4(a)(1)(A).

ISSUES PRESENTED

1. Whether the district court erred in granting summary judgment to the State on the claim that the Reimbursement Penalty violates providers' First Amendment rights of freedom of speech and association.

2. Whether the district court erred in granting summary judgment to the State on the claim that the Reimbursement Penalty is unconstitutionally overbroad.

3. Whether the district court erred in holding that the Reimbursement Penalty is severable from the Patient Disclosure Mandate.

STATEMENT OF FACTS

A. End-Stage Renal Disease Is A Life-Threatening Disorder That Severely Affects Vulnerable Populations

Kidney disease is both life-altering and life-threatening. That is especially true of ESRD, which is the last stage of chronic kidney disease when kidneys no longer can filter blood. 4-ER-613. ESRD patients will die within weeks without either a kidney transplant or regular dialysis, a complex procedure through which a machine removes, filters, cleans, and replaces the patient's blood. A patient typically requires dialysis three times a week, for four hours a session, in special hemodialysis centers. 4-ER-613; 4-ER-615. Although a kidney transplant is generally preferable, a years-long waitlist (up to 10 years in California) and limits on eligibility mean that the vast majority of ESRD patients need dialysis, many for the rest of their lives. 4-ER-614. In California alone, there are more than 100,000 people living with ESRD who need frequent dialysis simply to stay alive. 5-ER-873. Plaintiffs-appellants here ("Providers") are three healthcare providers that deliver dialysis to ESRD patients.

Medical care for ESRD patients is expensive, and ESRD typically afflicts low-income individuals who can least afford to bear these costs. 4-ER-615. In addition to the cost of dialysis, ESRD patients must pay for high-cost drugs and

medical care for serious comorbidities such as heart disease, diabetes, and cancer. 4-ER-854; 2-ER-110. Yet more than 80% of ESRD patients are unemployed because the disease's debilitating effects and extensive treatment regimen make it difficult to maintain a job. 4-ER-615. This burden disproportionately falls on racial and ethnic minorities, who suffer from ESRD at higher rates than white patients. *Id.*

B. Private Insurance Is A Vital Option For ESRD Patients

Given these extraordinary costs, ESRD patients generally require health insurance. 4-ER-615-616. But because many patients are unemployed due to the burdens imposed by ESRD, they often cannot access employer-sponsored health insurance or afford to pay for insurance themselves.

Over the years, the federal government has worked to ensure that ESRD patients have the ability to choose either public or private insurance. On the public side, Congress in 1972 made Medicare available to patients diagnosed with ESRD regardless of age, even though Medicare typically is available only for older Americans. 42 U.S.C. § 426-1(a). Congress simultaneously preserved the option for ESRD patients to continue using private insurance. *Id.* § 426-1(b).

When Medicare became available, many private insurers sought to avoid having to cover those patients' care by driving them onto that public program. Congress responded in 1981 by expanding the Medicare Secondary Payer Act to

require employer group health plans to assume primary payment responsibility for ESRD patients for a 12-month period following an ESRD diagnosis. 42 U.S.C. § 1395y(b)(1)(C). To ensure that private insurers meaningfully share in taking financial responsibility for ESRD patients, Congress has twice increased that period, to 18 months in 1990 and to 30 months in 1997. And in 2010, Congress enacted the Patient Protection and Affordable Care Act to bar insurers from denying coverage based on pre-existing conditions, including ESRD. 42 U.S.C. §§ 300gg-1(a), 300gg-4(a).

Federal law preserves ESRD patients' ability to access private insurance because that option is critical for many such patients. While as many as 90% of ESRD patients are enrolled in Medicare, 4-ER-625, Medicare is unavailable, inadequate, or simply undesirable for others. Some are ineligible, for example, because of their immigration status or because they lack the required work credits. 4-ER-616; 4-ER-617-618; 4-ER-624. Private insurance also often lowers patients' costs for care. 4-ER-617. For example, unlike most private insurance, Medicare requires 20% coinsurance payments for many procedures, including dialysis, and does not cap out-of-pocket costs. 4-ER-616-617. And California does not require that supplemental coverage for these costs ("Medigap") be available to ESRD patients under age 65. 2-ER-136. Even with public insurance, therefore, ESRD patients may be responsible for thousands of dollars in healthcare costs annually.

5-ER-1077. Prescription coverage is also often better and cheaper with private insurance—a key consideration for ESRD patients who often require a dozen different medicines each day. 4-ER-618; 4-ER-840. And Medicare does not cover family members unless they independently qualify (*i.e.*, generally those over 65). 4-ER-618-619; 4-ER-621. Take, for example, the children of a 35-year-old working mother who were covered by her employers' plan until ESRD forced their mother from her job. Medicare would cover the mom, but not the kids.

Private insurance is also a valuable option for some patients because it is associated with better health outcomes, including better access to kidney transplants. As the State's expert acknowledged, "privately insured patients tend to do better than patients on public insurance," and there is "a significant relationship between insurance status and access to transplantation." 4-ER-726-729; 4-ER-620. In fact, "many transplant centers"—which are unrelated to dialysis providers—will not serve Medicare patients who have no supplemental private coverage. 4-ER-619-620. And while many private plans include dental coverage, "traditional Medicare" does not. 4-ER-765; *see* 4-ER-618; 4-ER-856. A dental infection can threaten the viability of a transplant, leading to removal from a transplant list. *Id.*

The federal government has also long relied on private insurance to share the costs of ensuring the viability of the dialysis system. For example, Congress

specifically passed legislation to require that private insurance take primary responsibility for many ESRD patients. *See supra* pp.7-8. Providers and private insurers ordinarily negotiate reimbursement rates. Those rates are often higher than the rates the federal government sets through Medicare or Medicaid—which can be at or below providers' costs. 4-ER-625-626. Without a mix of private and public payers, the federal government would be forced to bear the costs of treating ESRD patients alone and dialysis clinics could be forced to close or cut back, to the detriment of all who rely on those clinics' services. 4-ER-693.

C. AKF Provides Critical Support To ESRD Patients Through A Wide Array Of Advocacy, Educational, And Charitable Efforts

Health insurance is thus vital for countless ESRD patients. But many simply could not afford it without financial assistance. Enter AKF. AKF has long been the leading advocate for the millions of Americans living with kidney disease, including ESRD. Operating as a nonprofit charitable organization since 1971, AKF's mission is to improve the lives of ESRD patients. 4-ER-621-622. It fulfills that mission in numerous, interrelated ways. AKF lobbies on behalf of ESRD patients before state and federal governments, 5-ER-875-876; 4-ER-622, offers "professional education programs for those who care for kidney patients," 2-ER-215, and "educate[s] the public about the risks for kidney disease," 2-ER-199; 2-ER-215. AKF also provides screening and prevention programs and supports

innovative research. 2-ER-215. AKF does all this to "ease the incredible burden that kidney disease inflicts on patients and their loved ones." 5-ER-875.

AKF's principal patient-support program is the Health Insurance Premium Program ("HIPP"), through which AKF provides "charitable premium assistance"—that is, help paying insurance premiums—to more than 70,000 low-income ESRD patients nationwide, including more than 3,000 Californians. 4-ER-623-624. To qualify for HIPP, a patient's monthly household income may not exceed their monthly expenses by more than $600. 2-ER-139. The average annual income of HIPP recipients in California is less than $32,000. 2-ER-140.

Patient choice is at the center of HIPP. 5-ER-877; 4-ER-616; 4-ER-623-624. AKF maintains a "strict policy of neutrality among insurance providers," allowing HIPP recipients to use grants to pay for whatever form of insurance they prefer. 5-ER-878-879; 4-ER-623. The majority of HIPP recipients—both nationwide and in California—choose public insurance options. 5-ER-878-879. More often than not, therefore, HIPP grants help ESRD patients pay the premiums for their Medicare-related coverage, such as Medicare Part B or Medigap. 4-ER-644; 5-ER-912; 5-ER-877-879. AKF reports, for example, that roughly 60% of HIPP recipients in California maintain public insurance. 5-ER-878-879. HIPP recipients also are free to choose private insurance if it better suits their needs. 5-ER-878-879; 4-ER-616-617; 4-ER-644. Among the minority in California who

opt for private insurance, most use HIPP funds to maintain the plan they had before being diagnosed with ESRD. 4-ER-645. HIPP thus works to secure for poor ESRD patients the same freedom that wealthier patients enjoy: the choice of health insurance that is right for them and their family.

Over 80,000 donors support AKF's extensive advocacy, educational, and charitable efforts. 4-ER-622-623. Contributors in California include nephrologists, cardiologists, pulmonologists, and other medical professionals who treat patients with kidney disease and associated ailments. 4-ER-623. Providers here are among those who associate with and demonstrate their support for AKF by making significant contributions. 4-ER-627-628; 4-ER-630-631. Those contributions are intended to and in fact enable AKF to advance its advocacy, educational, and charitable programs. 5-ER-884-885; 4-ER-694-695.

Charitable contributions to AKF are quite substantial; it has been publicly reported that some providers contribute more than $100 million in a year. AKF has autonomy over how to use those contributions. 5-ER-880-881. And, when AKF uses them to fund patient assistance through HIPP, patients likewise can choose how to use the charitable assistance: Patients can elect to use HIPP funds for public options, to retain their private insurance, or to switch onto a private insurance plan that is better for them or their family. 5-ER-878-879; 4-ER-644-645. As explained, *see supra* pp.3, 10, when Providers treat patients who use HIPP

funds to pay for private insurance that helps to cover the cost of dialysis treatments, Providers receive higher reimbursement rates than they would if the patient were forced onto Medicare. 4-ER-693. Those higher rates are the ones that Providers and insurance companies have agreed upon through arms'-length negotiations, typically between large and sophisticated companies on both sides. 3-ER-565-566; 3-ER-568; 3-ER-571. The higher rates for even that small group of patients also can be the difference between a dialysis clinic staying in business and having to close. 4-ER-693.

Providers are committed to patient choice and never direct HIPP recipients (or anyone else) to choose a particular insurance option. 4-ER-698-699. In fact, Providers specifically prohibit such steering. *Id.* Instead, as federal law requires, Providers offer fact-based information about insurance options that empowers patients to make their own decisions. *Id.*; *see* 42 C.F.R. § 494.80; U.S. Dep't of Health & Human Servs., *ESRD Surveyor Training Interpretive Guidance* 193 (Oct. 3, 2008); 4-ER-636-637.

The federal government has long endorsed both HIPP in general and Providers' support for it. After Congress enacted a beneficiary inducement statute barring medical providers from paying anything of value to induce certain patients to use their services, 42 U.S.C. § 1320a-7a(a), AKF and Providers asked the Inspector General of the U.S. Department of Health and Human Services ("HHS")

to evaluate whether Providers' HIPP contributions are lawful. 4-ER-626; 4-ER-772. In 1997, HHS issued Advisory Opinion 97-1, confirming that the contributions do not violate the beneficiary inducement law. 4-ER-772. HHS confirmed that AKF is "a *bona fide*, 501(c)(3) charitable and educational organization," and that HIPP "provides direct financial support in the form of grants to needy persons with ESRD for items such as … insurance premiums." 4-ER-773-774. Providers are "free to determine whether to make contributions to AKF and, if so, how much to contribute." 4-ER-775. And "'AKF's discretion as to [the] uses of the contributions'" remains "'absolute, independent, and autonomous.'" 4-ER-776. In particular, Providers committed to donating to AKF "'without any guarantee or promise'" that their donations would support particular patients who go to any particular dialysis clinic. *Id.* So it should come as no surprise that more than 50% of the dialysis providers that have referred patients to HIPP do not even contribute to AKF. 5-ER-885. These guardrails ensuring free choice about where to receive healthcare remain in place today.

D. Private Health Insurers Drive California To Enact AB290 Based On Purported Concerns About Patient "Steering"

For decades, AKF supported ESRD patients and Providers supported AKF, all with the blessing of the federal government. It worked for everyone—except private insurance companies. As noted, private insurers have long tried to push ESRD patients (and their expensive health costs) off their rolls and onto Medicare.

HIPP allows patients to stay on the insurance of their choice, whether public or private. Insurers tried to sever that link, creating a narrative that this life-saving support system in fact is a tool for Providers to "steer" patients onto private insurance against patients' best interest.

After years of lobbying, insurers and their allies persuaded the California Legislature to enact AB290. 4-ER-631. As relevant, AB290 restricts how healthcare providers can speak to their patients and penalizes them for making financial contributions to charitable premium-assistance programs like HIPP. The Legislature passed the law over the emphatic objections of leading patients' groups; medical groups, including the California Medical Association, the Renal Physicians Association, and the National Hispanic Medical Association; and the California chapter of the NAACP. 4-ER-632; 4-ER-781-782; 4-ER-784-787.

AB290 purports to address concerns with patient "steer[ing]." AB290 §1(i). The legislative findings accuse "financially interested" providers of "[e]ncouraging patients to enroll in commercial insurance coverage for the financial benefit of the provider." AB290 §1(c). Such steering purportedly "can … expose patients to harm;" cause "[c]onsumers [to] pay higher health insurance premiums due to the distortion of the insurance risk pool;" and contribute to "a market failure that has allowed large dialysis organizations to use their oligopoly power to inflate … the

cost of care." AB290 §1(d)-(e), (i). The findings expressly single out AKF and large dialysis providers who contribute to it. AB290 §1(h).

Based on those premises, AB290 enacted the following provisions at issue here:

"The Advising Restriction." AB290 regulates dialysis providers' ability to communicate with their patients, prohibiting them from "steer[ing]," "direct[ing]," or "advis[ing]" their patients "regarding" insurance options. AB290 § 2(a).[1] Violations of the Advising Restriction are criminal offenses under California law, may result in civil penalties, and can even force clinics to close. 1-ER-37; Cal. Health & Safety Code §§1229-1229.1, 1235-1238, 1240-1245. The provision's broad, vague terms reach the provision of truthful information. The Advising Restriction thus criminalizes even accurate and complete advice about a patient's health insurance options.

"The Reimbursement Penalty." Section 3 of AB290 imposes harsh financial sanctions on healthcare providers that associate with and financially support charities operating premium-assistance programs. As its proponents explained, the Penalty aims to "remove the incentive[s]" for healthcare providers

[1] AB290 imposes parallel changes on existing state laws governing managed care plans under §3 and health "insurers" under §5. Because the provisions are materially identical, for ease of exposition, this brief refers to §3. Citations to AB290 reflect the organization of the enacted bill, rather than the California Code.

to contribute to AKF. *See* AB290 Assembly Floor Analysis (Sept. 9, 2019) at 3. The statute applies broadly to all kinds of providers and charities, but it targets "the American Kidney Fund" and "the two largest dialysis companies"—that is, two of the Providers here. AB290 §1(g), (j).

The Penalty is triggered when a "financially interested provider" has a "financial relationship" with a "financially interested entity." AB290 §3(e). If (1) a "financially interested entity" provides premium assistance to a patient, and (2) a "financially interested provider" that has a "financial relationship" with that charity treats the patient, then (3) the provider receives reimbursement for those services at "the Medicare" rate rather than the rate the provider negotiated with the patient's insurance company. AB290 §3(e). Charities that provide premium assistance are "financially interested" if they receive a majority of their funding from "financially interested providers." AB290 §3(h)(2)(B). Providers are "financially interested" based on their size or if they "receive[] a direct or indirect financial benefit from a third-party premium payment." AB290 §3(h)(2)(A), (C).[2] The statute does not define "financial relationship."

[2] The only exception is for dialysis clinics that have "no more than 10 percent of California's market share of licensed chronic dialysis clinics." AB290 §2(h)(2)(C).

As relevant here, then, the Penalty overrides the negotiated reimbursement rates of dialysis providers who donate to AKF and treat AKF-supported patients. When such a provider treats an AKF-supported patient, the Penalty caps reimbursement that the insurance company must pay at the Medicare rate, which is often at or below the cost of providing dialysis and typically well below the rate that the insurers negotiated with the provider. 4-ER-625-626; 4-ER-857. A provider may try to limit the extent of the financial penalty only by way of an ill-defined (and as yet non-existent) alternative dispute resolution process. AB290 §3(e)(1), (f). Nothing in AB290 requires insurers to pass this windfall along to patients.

"Patient Disclosure Mandate." To facilitate the Reimbursement Penalty, AB290 requires AKF to give private insurers the names of patients who receive charitable assistance. AB290 §§3(c)(2), 5(c)(2). That mandate applies even if patients wish to remain anonymous. According to the State, the Patient Disclosure Mandate is "essential" to making the Reimbursement Penalty work because it enables insurers to know which patients receive HIPP assistance. 2-ER-91. In the State's words, "sections 3(c)(2) and 5(c)(2) are vital for AB 290's reimbursement cap to function properly—or even at all." 2-ER-96. "Without such disclosures," the State acknowledges, "the reimbursement cap provisions would effectively be unenforceable." 2-ER-95.

E. Providers, AKF, And Patients File Suit, And The District Court Enjoins AB290

AKF repeatedly informed the Legislature that the law would force AKF to cease its charitable operations in California. 5-ER-1084-1085. Sudden loss of AKF's HIPP support would cause thousands of low-income ESRD patients to lose their health insurance—and potentially access to life-saving care—virtually overnight. 5-ER-1084-1087; 5-ER-881-882; 5-ER-886. Some patients with private insurance would not be able to shift to Medicare because they do not qualify, 4-ER-858; 5-ER-1079-1080, or could not afford it without AKF's help, 4-ER-858-859; 5-ER-1079. Others might suffer negative health consequences, including with respect to eligibility for transplants. 4-ER-648-649. And patients already on public insurance no longer could rely on HIPP to afford premiums for Medicare-related coverage. 4-ER-616-617.

To avert that crisis and to protect their First Amendment rights, Providers, AKF, Dialysis Patient Citizens (a leading ESRD patient association), and individual ESRD patients immediately sought to enjoin these provisions of AB290. *See* 5-ER-1088; 2-ER-271.[3]

The district court preliminarily enjoined AB290 on December 30, 2019. 2-ER-948. The State's defense centered on its claim that AB290 was necessary to

[3] These two separate suits were related and proceeded in parallel until April 2022, when they were formally consolidated. 2-ER-98.

"prevent[] patient steering," but the court found the record wholly insufficient to establish that "these recited harms are real." 5-ER-955. Indeed, the court stressed, the "State has yet to identify a single California patient steered into a private insurance plan." 5-ER-955. The State hoped to prove "in discovery" that steering harms insurance markets, although the court noted that if these harms were real, the State would "*already* understand and be able to demonstrate these economic effects—and one would certainly expect to find more than the anemic allegation of risk-pool distortion in AB290 § 1(e)." 5-ER-955.

The district court also rejected the State's claim that the Reimbursement Penalty did not burden charitable contributions, reasoning that it "*functionally* burdens dialysis providers' freedom to contribute [to AKF] by strongly disincentivizing such contributions." 5-ER-957. But the court found "a question of fact" as to whether contributions to AKF are, in fact, "charitable in nature" or are "nonexpressive commercial or economic conduct" that lack First Amendment protection. 5-ER-958. The State chose not to appeal the decision granting the preliminary injunction and thus AB290 remained enjoined and unimplemented over the years that followed.

The case proceeded to discovery and summary judgment briefing in 2022. The State conceded several important points at summary judgment. First, it could not identify a single ESRD patient in California steered by a provider. 4-ER-638.

Second, its own agency witnesses were unaware of any instance of steering or even a complaint that steering had occurred. 4-ER-638-640. Third, it could point to no examples of any patient in California being harmed by alleged steering onto private insurance. 4-ER-640-642. Fourth, neither the State nor its expert witness identified any evidence of distortions in the insurance risk pool attributable to steering. 4-ER-645-648. Fifth, all agreed that AB290 had been pushed by private insurers and their allies. 4-ER-631. Finally, the State conceded that one "reason[] why Plaintiffs … contribute" to AKF is "because they believe in AKF's mission," 4-ER-627, and it declined to rebut the significant evidence showing Providers' charitable and expressive motivations, *see* 2-ER-100-101; 5-ER-909-910; 2-ER-108.

F. The District Court Holds Key Provisions Of AB290 Unlawful, But Upholds The Reimbursement Penalty

The district court granted in part and denied in part the parties' cross-motions for summary judgment on January 9, 2024. *See* 1-ER-12. The court first held that the Advising Restriction violates the First Amendment because it imposes a content-based restriction on commercial speech and does not advance a substantial interest at all, much less directly advance such an interest in a narrowly drawn way. 1-ER-38-46. Despite extensive discovery, the State offered only "'speculation or conjecture' regarding harm resulting from the purported steering." 1-ER-43. Thus, "[b]ecause the State still cannot identify a single California patient

steered into a private insurance plan[,] … supposed patient harm is too speculative and conjectural to support the State's professed interest of protecting patients." 1-ER-44 (internal quotation marks and citations omitted). The court also determined that the State had introduced no competent evidence "that any purported steering has distorted, or will distort, California's" insurance markets. 1-ER-45.

The court nonetheless upheld the Reimbursement Penalty. Notwithstanding the State's concession that Providers' charitable contributions were made at least in part to support AKF's expressive mission, the court deemed such contributions "transactional" rather than "expressive." 1-ER-50. It stated that the contributions were "a quid pro quo arrangement that 'secure[s] a later return on investment' in the form of higher private insurance reimbursements," and thus "do[] not implicate Plaintiffs' right to associate with AKF." 1-ER-49-50 (citation omitted).

Although the court held that the First Amendment did not apply, it nonetheless said it was applying "intermediate scrutiny." 1-ER-49. The court did not invoke the rationale for AB290 that it had previously rejected—that purported steering to private insurance harms patients and distorts the State's insurance risk pools. Instead, it seized on a harm the State referenced only in passing, *see* 3-ER-358; 5-ER-937: that the Reimbursement Penalty addressed a "market failure" in the dialysis industry whereby the purported "oligopoly power" of large dialysis providers leads to artificially high reimbursement rates. 1-ER-51. Citing no

evidence of either oligopoly power or inflated reimbursement rates—and failing to recognize that the State itself saw this "market failure" as simply a follow-on consequence of steering, 3-ER-358; *see also* 5-ER-937—the court found that the Reimbursement Penalty "directly advances the State's interest in neutralizing the reimbursement rates for commercial insurance." 1-ER-51.

The court did not address Providers' separate challenge that the Reimbursement Penalty is an unconstitutionally overbroad restriction of other providers' and charities' First Amendment rights. 4-ER-680.

Next, the court held that the Patient Disclosure Mandate—which requires AKF to divulge to insurers the names of patients who receive HIPP assistance—violates AKF's associational rights. 1-ER-54. The court then severed the invalid Patient Disclosure Mandate from the Reimbursement Penalty, stating that it "d[id] not affect the enforceability of" the Penalty. 1-ER-66.

The State moved for partial reconsideration of the district court's summary judgment order, arguing that by striking down the Patient Disclosure Mandate, the court had "struck down statutory provisions that are essential to the reimbursement cap's implementation" and "vital for AB 290's reimbursement cap to function properly—or even at all." 2-ER-90-97. The court denied that motion. 1-ER-8.

The State then agreed to a final judgment that, despite the court's decision upholding the Reimbursement Penalty, extended the injunction of that provision

through the duration of appeal. 1-ER-3-7. Providers, AKF plaintiffs, and the State all appealed. The law remains enjoined in its entirety today, as it has been for the past five years.

SUMMARY OF ARGUMENT

The Reimbursement Penalty violates the First Amendment because it penalizes core associational and expressive activities. It should be struck down for the following, independently sufficient reasons.

First, the Penalty unconstitutionally burdens Providers' rights of expression and association by imposing harsh financial penalties for making charitable contributions to AKF. The district court's assertion that Providers' contributions are not expressive conflicts with the State's concession, and the undisputed record, that Providers contribute to AKF in part for expressive reasons. And the court's conclusion that the First Amendment does not protect association or expression that carries an economic benefit was wrong as a matter of law.

The Reimbursement Penalty is therefore subject to at least exacting scrutiny, and it fails *any* form of heightened First Amendment review. The State offered no evidence of patient steering, let alone that such supposed steering harmed any patient or the insurance risk pool. The State could not identify a single patient who had been steered to private insurance. And the State's only expert witness on this topic *assumed* that all patients with private insurance were improperly steered and

still had to admit that he could identify no harm to insurance risk pools in California. The district court struck down the Advising Restriction based on precisely this lack of evidence. As for the court's alternative rationale, the State never attempted to make a case for this "market failure" justification, and so unsurprisingly there is no evidence to support it. And even if any of these problems did exist, the Reimbursement Penalty burdens far more protected activity than necessary and so is insufficiently tailored under the First Amendment.

Second, the Reimbursement Penalty is unconstitutionally overbroad, a defect the district court ignored altogether. The Penalty captures charitable donations of any size from any healthcare providers and to charities that have no connection to kidney disease at all, and who therefore lack even a theoretical reason to steer ESRD patients towards any particular type of insurance. The Penalty thereby creates "a realistic danger" that it "will significantly compromise recognized First Amendment protections of parties not before the Court." *Green v. Miss U.S.A., LLC*, 52 F.4th 773, 800 (9th Cir. 2022).

Third, the Reimbursement Penalty is inseverable from the Patient Disclosure Mandate, which the district court correctly held to be unconstitutional. As the State admitted, without the Patient Disclosure Mandate, "health plans and insurers would have no mechanism to identify the patients for whom the [Reimbursement Penalty] should apply, and thus the reimbursement cap provisions *would effectively*

be unenforceable." 2-ER-95. Because the Reimbursement Penalty cannot "stand on [its] own, unaided by the invalid provisions," it must be struck down. *Garcia v. City of Los Angeles*, 11 F.4th 1113, 1120 (9th Cir. 2021).

STANDARD OF REVIEW

This Court "review[s] de novo the district court's decision on cross motions for summary judgment." *Trunk v. City of San Diego*, 629 F.3d 1099, 1105 (9th Cir. 2011). In doing so, the Court "employ[s] the same standard used by the trial court," and "determine[s] whether there are any genuine issues of material fact and whether the district court correctly applied the relevant substantive law." *Animal Legal Def. Fund v. U.S. Food & Drug Admin.*, 836 F.3d 987, 988-989 (9th Cir. 2016). The Court "view[s] the evidence in the light most favorable to the non-moving party and draw[s] all reasonable inferences in its favor." *National Ass'n of Wheat Growers v. Bonta*, 85 F.4th 1263, 1274 (9th Cir. 2023).

ARGUMENT

I. THE REIMBURSEMENT PENALTY UNCONSTITUTIONALLY BURDENS FIRST AMENDMENT EXPRESSION AND ASSOCIATION

The Reimbursement Penalty violates foundational First Amendment principles. In purpose and effect, it imposes a substantial financial penalty on healthcare providers because they associate with and support AKF, an expressive, charitable organization. Worse, the problems the Reimbursement Penalty is meant

to solve simply do not exist. The only practical effect of the Reimbursement Penalty will be to harm the very patients it purports to help.

The district court's decision upholding the Penalty is wrong for the following reasons. *First*, the First Amendment unquestionably protects charitable contributions to expressive associations, such as Providers' contributions to AKF. *See infra* § I.A.1. The district court's determination that First Amendment protections do not apply, simply because Providers derive economic benefits from such contributions, was error as a matter of law. And, as the undisputed facts show—and as the State itself conceded below—Providers donate to AKF in part for charitable, expressive reasons. *See infra* § I.A.2. Their contributions are therefore entitled to First Amendment protection.

Second, the Reimbursement Penalty cannot survive any form of heightened constitutional scrutiny because there is *no* evidence of the problems that AB290 supposedly solves. *See infra* § I.B.1. The district court correctly agreed that there was no evidence of so-called "patient steering." *See infra* § I.B.2.a. There is similarly no evidence of a "failure" in the insurance markets, the alternative justification the district court credited in upholding the law. *See infra* § I.B.2.b. And even if there were such evidence of a problem, numerous alternatives could directly address these purported concerns without trampling First Amendment

rights by imposing severe financial penalties for exercising them. *See infra* § II.B.2.c.

A. The District Court Erred In Holding That The First Amendment Does Not Protect Providers' Charitable Contributions

1. The First Amendment protects Providers' charitable contributions to AKF

The district court erred as a matter of law in concluding that Providers do not engage in expressive association when they make charitable contributions to AKF merely because those contributions also bring a financial benefit.

Start with first principles: The First Amendment protects associating with any group that "engage[s] in some form of expression, whether it be public or private." *Boy Scouts of Am. v. Dale*, 530 U.S. 640, 648 (2000). That is true regardless of "whether the beliefs sought to be advanced by association pertain to political, economic, religious or cultural matters." *NAACP v. State of Ala. ex rel. Patterson*, 357 U.S. 449, 460-461 (1958). These critical protections extend to "charitable … activities." *Roberts v. United States Jaycees*, 468 U.S. 609, 627 (1984).

Just as membership in a charitable organization is protected, *Roberts*, 468 U.S. at 622-623, so are charitable contributions. As the Supreme Court explained in the political context, a "contribution 'serves as a general expression of support'" for, and "serves to affiliate a person with," the candidate. *McCutcheon v. FEC*, 572

U.S. 185, 203 (2014) (quoting *Buckley v. Valeo*, 424 U.S. 1, 21-22 (1976)); *see also id.* ("When an individual contributes money to a candidate, he exercises both those rights" of "political expression and political association"). Contributions also "enable[] speech" by helping the recipient "communicate a political message with which the contributor agrees." *Nixon v. Shrink Missouri Gov't PAC*, 528 U.S. 377, 400 (2000) (Breyer, J., concurring) (citing *Buckley*, 424 U.S. at 24-25).

That is equally true of charitable contributions: "[C]ontributions, in both charitable and political contexts, function as a general expression of support for the recipient and its views and, as such, are speech entitled to protection under the First Amendment." *Kamerling v. Massanari*, 295 F.3d 206, 214 (2d Cir. 2002). And charitable contributions also enable charities to "inform[]" and "persua[de]" others of "their views on economic, political, or social issues." *Village of Schaumburg v. Citizens for a Better Environment*, 444 U.S. 620, 632 (1980). Without contributions, "the flow of such information and advocacy would likely cease." *Id.* The Supreme Court drove home this principle in *Bonta*, which struck down a California law that abridged donors' First Amendment right to associate with charities by requiring that they disclose their identities to the state. 594 U.S. at 618. None of this is disputed, nor could it reasonably be.

It also is undisputed that AKF is a bona fide charitable organization that undertakes significant expressive activity. The State conceded that AKF engages

in advocacy (including political lobbying) and education (private and public). 4-ER-622; *see* 2-ER-124. These are indisputably constitutionally protected activities. *See, e.g.*, *Roberts*, 468 U.S. at 627 (First Amendment protects "lobbying"); *Dale*, 530 U.S. at 649-650 (same for nonprofit group's private educational efforts).

The charitable assistance that AKF provides is also expressive in its own right. As the Supreme Court has recognized, "charitable … activities [are] worthy of constitutional protection under the First Amendment." *Roberts*, 468 U.S. at 627; *see also Krishna Lunch of S. Cal., Inc. v. Gordon*, 797 F. App'x 311, 313 (9th Cir. 2020) ("distribution of sanctified vegan and vegetarian food" was "expressive conduct for purposes of First Amendment protection"); *cf. Loper v. New York City Police Dep't*, 999 F.2d 699, 704 (2d Cir. 1993) (a person "holding out his or her hand or a cup to receive a donation itself conveys a message of need for support and assistance"). HIPP is "one component of AKF's broader effort to advance public policy." 2-ER-236. The program embodies and communicates AKF's core mission of advancing the welfare of ESRD patients, 4-ER-691-692, along with AKF's belief that ESRD patients deserve adequate care and the right to choose the insurance that best meets their needs, regardless of their ability to pay. 4-ER-692.

2. Charitable contributions do not lose their First Amendment protection just because they provide a financial benefit

The district court misapprehended these core principles, and that threshold legal error infected its analysis of the Reimbursement Penalty.

The court started by correctly recognizing that the First Amendment protects the "right to associate for the purpose of engaging in protected speech" furthering "'a wide variety of political, social, economic, educational, religious, and cultural ends.'" 1-ER-46 (quoting *Roberts*, 468 U.S. at 622). Then it veered off course, holding that Providers' contributions to AKF were not "actually" "an expressive avenue by which providers join and support AKF's mission," and thus did not fall "under the aegis of the First Amendment." 1-ER-48; *see* 1-ER50. Why not? Because, the court said, dialysis providers "have much to gain financially" from the contributions. 1-ER-50 (quoting the State's argument). The court asserted that AKF and Providers' relationship was merely "transactional," and that the law targeted only "economic activity" that does not "implicate Plaintiffs' right to associate with AKF." *Id.* That conclusion is flawed for multiple reasons.

First, the court erred as a matter of law in concluding that the presence of an economic benefit means that charitable contributions are not "expressive" and so do not "merit constitutional protection." 1-ER-48 (citation omitted). The First Amendment's applicability does not turn on *why* someone engages in otherwise expressive or associational activity. And the First Amendment certainly protects

charitable contributions supported by a purportedly mixed motive that includes expressive and associative purposes. *See Preferred Commc'ns, Inc. v. City of Los Angeles*, 754 F.2d 1396, 1410 n.1 (9th Cir. 1985), *aff'd*, 476 U.S. 488 (1986) (cable television operator "does not lose its First Amendment rights merely because its judgment [about what to air] is tempered by commercial considerations"). After all, individuals, corporations, labor unions and others regularly engage in and support political, social, and charitable activities that benefit their economic interests. But that does not mean a state can prohibit small business owners from supporting political candidates who run on increasing small business grants, or prohibit a restaurant workers union from donating to a political action group supporting candidates who favor banning taxes on tips.

The Supreme Court could not be clearer about this. It is a "frequently stated principle that commercial activity, in itself, is no justification for narrowing the protection of expression secured by the First Amendment." *Ginzburg v. United States*, 383 U.S. 463, 474 (1966). After all, "a great deal of vital expression" that is protected by the First Amendment "results from an economic motive." *Sorrell v. IMS Health Inc.*, 564 U.S. 552, 567 (2011). Even a "*purely* economic" motive would "hardly disqualif[y] [plaintiffs] from protection under the First Amendment." *Virginia State Bd. of Pharmacy v. Virginia Citizens Consumer Council, Inc.*, 425 U.S. 748, 762 (1976); *see also Bolger v. Youngs Drug Prods.*

Corp., 463 U.S. 60, 67 (1983) (existence of "economic motivation" for speech does not lessen First Amendment protection). The First Amendment protects "speech which 'does no more than propose a commercial transaction,'" *id.*, such as "Cola for 99 cents." Similarly, the First Amendment protects the "right to associate … in the pursuit of … economic … ends." *Roberts*, 468 U.S. at 622; *see also NAACP*, 357 U.S. at 460-461 (First Amendment protects associational rights regardless of whether "the beliefs sought to be advanced by association pertain to political, *economic*, religious or cultural matters." (emphasis added)). In short, government is "not free of constitutional restraint" merely because otherwise protected expression or association "involved financial gain." *Bigelow v. Virginia*, 421 U.S. 809, 818 (1975).

These protections cannot be evaded by simply recharacterizing charitable contributions as "conduct" or "economic activity" rather than speech or association, as the district court did here. 1-ER-48-51. The district court cited *Interpipe Contracting, Inc. v. Becerra*, but that case upheld a law that regulated "payment of wages," not charitable contributions, and this Court unsurprisingly held that the way an employer pays its employees is "employer conduct … that is not inherently expressive." 898 F.3d 879, 895 (9th Cir. 2018). The law in *Interpipe* allowed employers to satisfy the state's minimum-wage law in part with contributions to third-party advocacy groups—but only if their employees

consented. One advocacy group wanted employers to be able to contribute without their employees' consent. The group, in other words, wanted employers to be able to take wages they owed employees and give those wages away.

This Court rejected that argument. The Court explained that the "minimum wage law" at issue regulated "payment of wages," not charitable contributions. *Interpipe*, 898 F.3d at 895. And a "minimum wage law" "does not target conduct that communicates a message nor does such conduct contain an expressive element" or "bear a tight nexus … to free speech." *Id.* at 895-896. It did not matter that employers might want to fund their charitable giving by confiscating their employees' wages. The First Amendment does not protect theft just because the thief donates the ill-gotten gains. AB290, by contrast, penalizes healthcare providers for making specific charitable contributions with their own money. And *Interpipe* itself recognized that contribution limits "'operate in an area of the most fundamental First Amendment activities.'" *Id.* at 892 (quoting *McCutcheon*, 572 U.S. 196). Neither the district court nor the State cited any case holding that charitable contributions to an expressive organization lack First Amendment protection.

Second, even if the existence of an economic interest mattered, the court's opinion is irreconcilable with the undisputed record. There is no dispute that Providers make very large charitable contributions to AKF, that they benefit when

those contributions help patients obtain insurance that enables them to obtain medical care, and that Providers receive higher reimbursement for treating patients who choose private insurance. But the State also conceded that, among the "reasons why Plaintiffs … contribute" to AKF are that they "believe in AKF's mission," 4-ER-627—which includes educating patients with kidney disease, 4-ER-622—and that Providers often "share AKF's legislative priorities or public policy positions," 4-ER-628. Tellingly, the State disputed these facts only "to the extent [they] imply that there are *no other* reasons why Plaintiffs would contribute to AKF." *E.g.*, 4-ER-627 (emphasis added).

Indeed, each Provider made clear in undisputed declarations that their contributions reflect their strong belief in AKF's expressive, charitable efforts:

- "DaVita supports and contributes to AKF because DaVita believes strongly in AKF's mission," including its "efforts to educate the public on kidney disease prevention and treatment," as well as many of AKF's "legislative priorities." 2-ER-100-101. Such contributions, which help "enable AKF's patient-assistance, education, and lobbying work," also "express[] DaVita's support for and solidarity with AKF's mission." 2-ER-101

- Fresenius "contribute[s] to AKF … because it strongly believes in AKF's charitable mission." 2-ER-108. It "believes that all ESRD patients should have access to the insurance of their choosing," and "AKF's efforts to provide ESRD patients with the financial means" to access those choices "can have a substantial clinical and financial impact for these patients." 2-ER-108.

- U.S. Renal "agrees with AKF's positions on certain public policy issues, and it generally makes unrestricted donations knowing that AKF might use those funds to advance certain policy positions." 5-ER-909. It further agrees "that preventing kidney disease and educating patients and the public about that disease are important priorities." This has led USRC to make "a number of donations specifically for AKF's educational programs over the past several years," including "a $50,000 contribution in 2021 for Kidney Action Week, a free educational program that connected ESRD patients with kidney health experts." 5-ER-910.

These facts compel summary judgment in Providers' favor, not the State's.

That is doubly true in light of HHS Advisory Opinion 97-1, which weighed analogous concerns that Provider contributions to HIPP could influence patients' choice of healthcare provider. 4-ER-772-779. HHS concluded that these concerns were unfounded because AKF ensured that premium assistance "will follow a patient regardless of which provider the patient selects, thereby enhancing patient freedom of choice." 4-ER-776.

Here, those same guardrails preserve patient choice about insurance. AKF continues to maintain "absolute, independent, and autonomous" "discretion" over how contributions are used. 4-ER-776. Just as AKF does not condition aid on using particular healthcare providers, AKF does not consider whether they will use the aid for public or private insurance. 2-ER-173-174; 5-ER-23; *supra* pp.11-12. Nor do Providers condition their contributions on how or even whether AKF disburses HIPP funds. 2-ER-176-178. Indeed, the majority of recipients of HIPP

grants have public insurance. 4-ER-644; 5-ER-878-879. And many patients that receive HIPP funds obtain care from dialysis clinics that are not operated by Providers and do not donate to AKF. 5-ER-885 ("more than 50% of the companies whose clinics refer patients do not contribute to HIPP"). For the same reasons cited by Advisory Opinion 97-1, HIPP's structure ensures that Providers cannot run a "scheme" purely for "funneling money" back to themselves, as the district court imagined. 1-ER-49.

In any event, the Reimbursement Penalty triggers heightened First Amendment scrutiny even if one sets aside HIPP's plainly charitable purposes. As the State conceded, AKF engages in advocacy and education, and Providers donate to support those heartland expressive activities. The Reimbursement Penalty is not triggered only by charitable contributions earmarked for HIPP (i.e., those that financially benefit Providers), but by *any* contributions, including those used to fund AKF's advocacy or education programs. Thus, "when the Act is viewed in its entirety, it becomes clear that it controls more than contractual relations." *Pacific Coast Horseshoeing School, Inc. v. Kirchmeyer*, 961 F.3d 1062, 1069 (9th Cir. 2020). AB290 indiscriminately penalizes charitable contributions to an expressive organization and so "squarely implicates the First Amendment." *Id.*

Finally, even if the relative weight of the Providers' motivations were material to the First Amendment question, it would at minimum be genuinely

disputed. *See Santopietro v. Howell*, 73 F.4th 1016, 1028 (9th Cir. 2023) (reversing summary judgment for government where there was genuine dispute as to whether plaintiff's "actions were entirely protected expression" or "regulable commercial activity"). The Court found only that "the record supports" the State's argument as to Providers' economic motive. 1-ER-50. But at summary judgment, the facts must be beyond dispute. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 250 (1986). Summary judgment for the State was thus inappropriate.

B. The Reimbursement Penalty Fails Any Level Of First Amendment Scrutiny

1. The Reimbursement Penalty is subject to heightened constitutional scrutiny

For all the reasons just discussed, AB290 triggers First Amendment scrutiny. And because the Reimbursement Penalty squarely targets expression and association, it plainly must satisfy some form of heightened review. Indeed, because it imposes burdens on particular speakers in order to discourage particular contributions to particular recipients, the Penalty is subject to strict scrutiny. *See infra* pp.40-41. But the Court "need not parse the differences between the two standards in this case," *McCutcheon*, 572 U.S. at 199, because at a bare minimum the Reimbursement Penalty is subject to (and cannot survive) "exacting scrutiny." That standard requires the State to demonstrate a "substantial relationship"

between the Reimbursement Penalty and "a sufficiently important interest," and that its means are "narrowly tailored" to that interest. *Bonta*, 594 U.S. at 607.

Multiple lines of cases make clear that at least exacting scrutiny applies here. Exacting scrutiny applies to laws that restrict or burden charitable or political contributions. For example, disclosure requirements trigger exacting scrutiny because they have a "deterrent effect" on protected charitable or political contributions. *See id.* (quoting *Buckley*, 424 U.S. at 65); *see also Davis v. Federal Election Comm'n*, 554 U.S. 724, 744 (2008). Exacting scrutiny likewise applies to political contribution limits. *See McCutcheon*, 572 U.S. at 199. That is because, once a contribution limit is hit, the law "den[ies] the individual all ability to exercise his expressive and associational rights by contributing to someone who will advocate for his policy preferences"—a "clear First Amendment harm" that requires a sufficiently important interest and assurances that the law "'avoid[s] unnecessary infringement' of First Amendment rights." *Id.* at 205 (quoting *Buckley*, 424 U.S. at 25); *see also Bonta*, 594 U.S. at 609-610 (relying on *McCutcheon* in applying exacting scrutiny). The same logic applies to charitable contributions, for it is "'immaterial' to the level of scrutiny 'whether the beliefs sought to be advanced by association pertain to political, economic, religious or cultural matters.'" *Bonta*, 594 U.S. at 608 (citation omitted).

The Reimbursement Penalty similarly penalizes contributions to expressive organizations and thus is subject to (at least) exacting scrutiny. Indeed, the law's very purpose is to "remove the incentive[s]" for dialysis providers to contribute to AKF. AB290 Assembly Floor Analysis (Sept. 5, 2019) at 3. And "the burden imposed … is evident and inherent in the choice that confronts" providers. *Arizona Free Enter. Club's Freedom Club PAC v. Bennett*, 564 U.S. 721, 745 (2011). Providers can either (1) associate with and express support for AKF through charitable contributions, but face a heavy financial penalty, or (2) end their association with and support for AKF, but continue to receive "[p]rivate insurance reimbursement rates [that] are typically higher than public reimbursement rates," 4-ER-625-626. The consequences of this penalty are severe and random: clinics that happen to serve privately insured patients who benefit from HIPP assistance will experience an unexpected financial hit that could impact services or even force them to close. 4-ER-693; 3-ER-464-465. The Penalty thus strongly discourages Providers from contributing to AKF at all.

If anything, the Reimbursement Penalty deters protected contributions even more severely than in the Supreme Court's exacting scrutiny cases. The disclosure requirement in *Bonta* applied only to donors of more than $5,000 per tax year, 594 U.S. at 602, and the aggregate contribution limit in *McCutcheon* permitted contributions of "up to $123,200 to candidate and noncandidate committees during

each two-year election cycle," 572 U.S. at 194. The Reimbursement Penalty, by contrast, kicks in whenever a covered healthcare provider makes any contribution to a covered charity, no matter the size. And the harsh financial penalties here do far more than merely risk indirectly chilling expressive conduct, as in *Bonta*.

Adhering to a heightened form of constitutional review such as exacting scrutiny is particularly appropriate because the law takes aim at specific speakers. Although the law sweeps more broadly, *see supra* pp.16-17; *infra* pp.52-61, AB290 is intentionally aimed at a small number of actors—large dialysis providers and AKF. Indeed, AB290's findings single out "the two largest dialysis companies" in the United States, AB290 §1(g), and identify AKF by name, *id.* §1(j). A law targeting the protected conduct of only certain entities is inherently suspect and ordinarily subject to the highest forms of constitutional scrutiny. *See Minneapolis Star & Trib. Co. v. Minnesota Comm'r of Revenue*, 460 U.S. 575, 578, 592 (1983) (striking down a Minnesota tax on use of more than $100,000 of ink and paper in single year because it only burdened the state's largest newspapers); *Time Warner Cable, Inc. v. Hudson*, 667 F.3d 630, 638 (5th Cir. 2012) (holding that "[l]aws singling out a small number of speakers for onerous treatment are inherently suspect" and subject to heightened scrutiny). And the Supreme Court has made clear that the existence of an "economic motivation" for speech does not trigger a lesser form of scrutiny. *Bolger*, 463 U.S. at 67.

At the very least, the Penalty triggers intermediate scrutiny. After all, intermediate scrutiny applies to pure commercial speech—i.e., "speech which 'does no more than propose a commercial transaction." *Virginia State Bd. of Pharmacy*, 425 U.S. at 762. A penalty on charitable contributions deserves no less. Intermediate scrutiny requires the State to establish that a speech restriction (i) "furthers an important or substantial governmental interest" (ii) "in a direct and material way" and (iii) imposes burdens "no greater than [are] essential to the furtherance of that interest." *Turner Broadcasting Sys., Inc. v. FCC*, 512 U.S. 622, 662, 664 (1994); *see also Central Hudson Gas & Elec. Corp. v. Public Serv. Comm'n*, 447 U.S. 557, 566 (1980) (similar standard for commercial speech). For the reasons set forth below, the Reimbursement Penalty cannot possibly satisfy this standard.

The district court erred in assessing what level of scrutiny applies. Although it said it was applying a hybrid form of intermediate scrutiny, 1-ER-49, in practice the court failed to apply any meaningful First Amendment scrutiny at all. It adopted its own rationale for the Penalty (correcting a market failure, *infra* pp.49-52) and accepted this rationale without any factual support. These are hallmarks of bare-bones, rational-basis review. *See generally Heller v. Doe by Doe*, 509 U.S. 312, 320 (1993). That was error. As discussed next, the Penalty cannot survive any form of heightened scrutiny.

2. The Reimbursement Penalty fails any form of heightened scrutiny

Whether under strict, exacting, or intermediate scrutiny, it is "obvious [that] a state may not restrict protected speech to prevent something that does not appear to occur." *Junior Sports Mags. Inc. v. Bonta*, 80 F.4th 1109, 1117 (9th Cir. 2023). That is exactly what the State did here.

To prove an important or substantial interest under intermediate scrutiny, the government "must do more than simply posit the existence of the disease sought to be cured. It must demonstrate that the recited harms are real, not merely conjectural, and that the regulation will in fact alleviate these harms in a direct and material way." *Turner*, 512 U.S. at 664; *see also Ibanez v. Florida Dep't of Bus. & Pro. Regul., Bd. of Acct.*, 512 U.S. 136, 146 (1994). The State bears the burden of "demonstrat[ing] that it is regulating speech in order to address what is in fact a serious problem." *Edenfield v. Fane*, 507 U.S. 761, 776 (1993); *see also Klein v. City of San Clemente*, 584 F.3d 1196, 1202 (9th Cir. 2009). The State failed entirely to do that here—the Reimbursement Penalty provides a windfall to commercial health insurance payers, but it does not protect patients.

a. There is no evidence of any patient steering at all, much less of harm resulting from steering

At summary judgment, the State justified the Reimbursement Penalty on the theory that it would stop Providers from "steering" ESRD patients onto insurance

plans, which (the State says) harms patients and distorts insurance markets. *E.g.*, 3-ER-353. The State advanced the same rationale in support of the Advising Restriction, which prohibits advising, steering, or directing patients toward particular coverage. 5-ER-937 ("the same analysis used in considering the steering prohibition would apply" to "the reimbursement cap"); 3-ER-595 (same); 3-ER-357 (similar). Importantly, the district court struck down the Advising Restriction because the State offered no competent evidence of steering *at all*, much less evidence that steering caused patient harm or distorted insurance markets. 1-ER-41-46.

Not surprisingly, then, the district court did not rely on the steering rationale to uphold the Reimbursement Penalty. And properly so: The State *admitted* that it cannot identify a single California patient "steered" into a private insurance plan by a dialysis provider. 4-ER-699; 4-ER-638; 4-ER-640-641. Neither the State's expert witnesses nor its corporate designees could identify any actual steering that has ever occurred. 4-ER-702; 4-ER-699-700. State agencies regulating insurance are not even aware of any patient *complaints* on the issue. 4-ER-639-640. And given the absence of evidence of steering, the State of course identified no evidence of patient harm resulting from steering. Despite years of litigation while the Reimbursement Penalty was enjoined, the State and its witnesses came up empty.

This complete lack of evidence dooms the Reimbursement Penalty. As this Court recently confirmed in *Junior Sports*, "simply having a substantial interest does not validate" a law that restricts free speech. 80 F.4th at 1117. There, this Court struck down (under intermediate scrutiny) a prohibition on advertising firearms "in a manner that … reasonably appears to be attractive to minors." *Id.* at 1114. As here, "the state admitted … that it [was] unaware of a *single* instance" of the problem it was trying to solve by restricting speech. *Id.* at 1117; *compare* 1-ER-44 ("the State still cannot 'identify a single California patient steered into a private insurance plan by a dialysis provider or third-party payer'"); *see also Bonta*, 594 U.S. at 613 (crediting district court's finding that there "was not 'a single, concrete' instance" supporting California's claimed interest).

The best the State could do here was point to recycled speculation from various third parties, much of which did not even relate to purported steering. But the State's own speculation cannot carry its burden to establish that AB290 addresses a real problem. *See Junior Sports*, 80 F.4th at 1117-1118. Speculation from third parties therefore cannot either. *E.g.*, *Edenfield*, 507 U.S. at 770-771 (rejecting evidence that failed to establish non-speculative harms under intermediate scrutiny).

The State largely relied on a handful of mostly anonymous comments (and inadmissible hearsay) in the record of a since-abandoned HHS rulemaking that

speculated about alleged steering. *See, e.g.*, AB290 §1(e). But that rule was enjoined because the agency relied on a hastily assembled record riddled with "shortcomings and deficiencies." *Dialysis Patient Citizens v. Burwell* (*DPC*), 2017 WL 365271, at *5-6 (E.D. Tex. Jan. 25, 2017). And even that flawed record did not include a single claim from a patient about having been steered. HHS could only conjecture that providers "*may* be encouraging individuals to make coverage decisions based on the financial interest of the health care provider," which *"may* result" in harm to patients. 81 Fed. Reg. 90,211, 90,214 (Dec. 14, 2016) (emphasis added). HHS did not appeal, and it has done absolutely nothing in the years since the rule was enjoined to correct these deficiencies or reinstate the rule.

The State's smattering of other claimed evidence of steering was anemic, and likewise depends only on conjecture or unsupported inference. The State pointed to a Washington state agency investigation into whether one employee of one Provider signed up patients for commercial insurance without a license, which investigation did not evaluate steering and was "rescinded" with no findings of wrongdoing. 3-ER-434-436. Even further afield were the State's references to one Provider's program that truthfully educated patients about insurance options and ended 3 years before AB290 was enacted; another Provider's insurance-coordinator incentive plans; and a few unrelated lawsuits, news articles, and a

congressmember report. As the district court correctly concluded, none of these materials provided any evidence of actual steering. 1-ER-42.

Moreover, the State's burden here was not simply to establish patient "steering," but "steering" that harmed patients. "Steering" may sound like a dirty word, but to the extent it refers to providing truthful, non-misleading speech about insurance options, such speech would receive full constitutional protection. No one could complain about—or impose restrictions on—honest information that results in patients choosing to switch to a better health insurance plan. The State can restrain such speech only when the speech demonstrably creates harm.

Here, the State's concession is dispositive: It could not identify a single ESRD patient who was harmed by being directed to private insurance. 4-ER-640-642. As the district court correctly explained, the State's failure to adduce any evidence renders this "supposed patient harm … too speculative and conjectural to support the State's professed interest." 1-ER-44. After all, "the First Amendment requires more than fact-free inferences to justify governmental infringement on speech." *Junior Sports*, 80 F.4th at 1118. And merely proffering "hypothetical" possibilities certainly does not meet that burden. 1-ER-44.

It is hardly surprising that the State could not muster any reliable evidence of patient harm or steering. Providers specifically bar employees from directing or encouraging patients to enroll in particular insurance plans. 4-ER-698-699. That

choice belongs to patients. And while most patients choose public insurance, many have good reason to choose private insurance. *Supra* pp.8-9; *see* Hearing Tr. 84:17-20, *Doe v. Bonta*, No. 8:19-cv-02105-DOC-ADS, Dkt. 202 (N.D. Cal. Oct. 27, 2022) (State conceding that "[f]or some patients, commercial insurance may be a great choice for them"). The bare fact that some patients have chosen private insurance cannot be evidence of improper steering or patient harm. And to the extent the Reimbursement Penalty ends up depriving needy patients of their preferred insurance, it would be responsible for its own kind of harmful steering. The only harm to patients here comes from AB290 itself.

The State's other rationale—that alleged steering "raises health insurance premiums" by distorting "'the insurance risk pool,'" 3-ER-591 (quoting AB290 § 1(e))—founders on the absence of any evidence of steering. In any event, the State has no evidence that, "as a result" of steering, "California consumers will pay, or have paid, higher insurance premiums." 1-ER-44.

The State relied solely on the expert testimony of John Bertko on this point. But Mr. Bertko admitted at his deposition that his projected premium increases were based on "misstatement[s]," "mistake[s]", "guess[es]," and an "inaccurate" premise about the migration of ESRD patients to private insurance. 4-ER-647-648. And he acknowledged that, in recent years (when any purported steering would have occurred), California had "successfully … ke[pt] the health 'risk mix' …

consistent," with among the lowest average risk in the country, and "very low premium increases." 4-ER-646-647.

Mr. Bertko also analyzed the wrong questions. As the district court observed, "neither Mr. Bertko nor the State's other sources isolated the effect of ESRD patients who were supposedly steered by dialysis providers or entities like AKF—as opposed to ESRD patients who obtained private insurance for other reasons," 1-ER-44; *see* 4-ER-644, such as the Affordable Care Act's guaranteed-issue requirement, or because private insurance can be advantageous. To the contrary, Mr. Bertko estimated that 90% of the patients on which he based his cost projection already had private insurance *before* developing ESRD or receiving charitable premium assistance; these patients could not have been steered to private coverage by providers or due to HIPP. 3-ER-405.

"In the end, California spins a web of speculation—not facts or evidence—to claim that its restriction on speech will significantly curb" supposed patient steering or, relatedly, help control health insurance premiums. *Junior Sports*, 80 F.4th at 1119. That is fatal under any degree of First Amendment scrutiny.

b. There is no evidence of a market failure

Having determined that the Reimbursement Penalty was not supported by any steering-based rationale, the court advanced a justification that the State never even attempted to support. Specifically, quoting a conclusory legislative finding,

the court said that Providers and AKF were "artificially increasing the number of their patients who have commercial insurance coverage" and so the State needed to "correct a market failure that has allowed large dialysis organizations … to use their oligopoly power to inflate commercial reimbursement rates and unjustly drive up the cost of care." 1-ER-51 (quoting AB290 § 1(i)).

As an initial matter, to the extent the State even mentioned this supposed "market failure" theory, it was predicated on the same steering the court correctly found was absent. The State cited the alleged "market failure" justification only to "underscore the [Reimbursement Penalty's] purpose of reducing Plaintiffs' incentive to steer patients." 3-ER-358. As detailed above (at 43-49), there is no evidence that such steering is occurring.

More fundamentally, the court's effort to backfill a new justification for the statute is wholly insufficient under the First Amendment. The State carries the "burden" of establishing that the Penalty addresses "harms" that are "real, not merely conjectural," and that the statute is appropriately tailored. *Turner*, 512 U.S. at 664-665. It is not the district court's role to assert rationales on which the government did not rely. Here, the State collected no evidence to support this "market failure" rationale in discovery; presented no evidence to establish the rationale on summary judgment; and only mentioned that portion of AB290's

preamble in passing—and even then, only as part of the State's steering theory. *See* 3-ER-358; 5-ER-937.

The predictable result is a complete absence of evidence. No evidence establishes any market failure in the dialysis industry, that reimbursement rates are inflated because of a market failure, or that costs to consumers have risen as a result. Not one of the State's dozens of statements of uncontroverted facts identified any evidence of a market failure or the impact of any such failure on reimbursement rates. *See* 3-ER-421-465; 3-ER-404-417. None of the State's 30(b)(6) witnesses mentioned this rationale. The State proffered no economic expert to opine on the market power of any dialysis provider, the effect of hypothetical market power on negotiations for reimbursement rates with insurers, how the Penalty might align rates with what they would be in a world without a market failure, or how that would affect consumer costs. *Compare Turner Broad. Sys., Inc. v. FCC*, 520 U.S. 180, 196 (1997) (emphasizing the robust legislative record and other significant evidence of market power and abuse of that power before holding that the challenged rule survived intermediate scrutiny). In fact, the district court found that the State adduced no evidence that insurance rates are rising in California at all, much less due to the donations that AB290 targets. 1-ER-44-45. There certainly was no evidence of such harm caused by a "market failure" that exists nowhere in the record.

This total lack of proof is fatal because this is not a case where the "connection between the law restricting speech and the government goal is so direct and obvious that offering evidence would seem almost gratuitous." *Junior Sports*, 80 F.4th at 1118. To the contrary, insurers' reimbursement rates are generally part of arms'-length, heavily negotiated agreements with insurance companies who themselves have significant market power. 3-ER-565-566; 3-ER-568; 3-ER-571. Insurers use their significant leverage to refuse rates that they think are too high. 5-ER-1041-1042. While private insurance reimbursement rates are generally higher than public ones, that is true across every treatment and cannot be evidence of a market failure. Moreover, there is significant competition among providers in California, and the presence of nonprofit providers and potential competition exerts price-disciplining effects. 5-ER-1040; 3-ER-571. As a result, dialysis rates typically are lower in California than elsewhere. 5-ER-1041-1042. It certainly is not self-evident that there is any market failure here.

c. Even were there evidence of a problem, the Reimbursement Penalty is not appropriately tailored to solve it

The State also failed to show that AB290 is "not more extensive than necessary" to address those purported aims. *Cent. Hudson*, 447 U.S. at 566.

The Reimbursement Penalty does not directly regulate steering; instead, it is just the kind of "[b]road prophylactic rule[]" that "in the area of free expression

[is] suspect." *NAACP v. Button*, 371 U.S. 415, 438 (1963). "Precision of regulation must be the touchstone in an area so closely touching our most precious freedoms." *Id.*; *see also National Inst. of Fam. & Life Advocs. v. Becerra* ("*NIFLA*"), 585 U.S. 755, 775 (2018) (applying intermediate scrutiny). A law does not survive intermediate scrutiny if there are "practical and nonspeech-related forms of regulation" that "could advance the asserted interests 'in a manner less intrusive to [plaintiffs'] First Amendment rights.'" *Greater New Orleans Broad. Ass'n v. United States*, 527 U.S. 173, 192-193 (1999). "[T]he State's first resort" must be "specific, narrowly tailored laws" that target the purported problem at issue. *Packingham v. North Carolina*, 582 U.S. 98, 107 (2017).

These principles doom the Reimbursement Penalty. As to steering, the Penalty is vastly overbroad because there are far less drastic means of preventing providers from steering patients to private insurance plans. The state could bar enrollment in insurance plans that it views as less desirable. It could bar providers from making false or misleading statements about insurance options or require disclosing any financial interest. *See*, *e.g., Zauderer v. Office of Disciplinary Couns. of Supreme Ct. of Ohio*, 471 U.S. 626, 651 (1985). Moreover, "the ordinary course in a free society" is for the government to respond publicly to speech that it dislikes, not suppress it. *United States v. Alvarez*, 567 U.S. 709, 728-729 (2012). The State could engage in its own "public-information campaign" to educate

ESRD patients about insurance options. *NIFLA*, 585 U.S. at 775. "This procedure would communicate the desired information to the public without burdening a speaker[.]" *Riley v. National Fed'n of Blind of N. Carolina, Inc.*, 487 U.S. 781, 800 (1988). "The Government has not shown, and cannot show, why counterspeech would not suffice to achieve its interest." *Alvarez*, 567 U.S. at 726.

Nor is the law remotely tailored to address any concern about the health of California's insurance market. To the contrary, the State could have addressed that concern "more directly and effectively" with "nonspeech-related" alternatives. *Greater New Orleans*, 527 U.S. at 192. For example, the State could have directly regulated insurance premiums or reimbursement rates, provided subsidies, or created incentives for additional competitors to enter the dialysis market. Such alternatives would be less burdensome, and—unlike the Reimbursement Penalty—would actually and directly lower premiums for consumers rather than result in a windfall to insurers, thus advancing AB290's apparent purpose of lowering the cost of care.[4] "[R]egulating speech must be a last—not first—resort." *Thompson v. Western States Med. Ctr.*, 535 U.S. 357, 373 (2002). But "there is no hint that the Government even considered these or any other alternatives." *Id.* The State in fact

[4] In that regard, it is telling that no provision of AB290 requires private insurers to pass on any purported cost savings to consumers. 4-ER-695.

conceded that it did not know if the Legislature considered any more tailored alternatives. 4-ER-632.

Moreover, as a mechanism to address any purported oligopoly in the dialysis market, the Reimbursement Penalty is "wildly underinclusive." *See NIFLA*, 585 U.S. at 774. It targets only a subset of Providers' allegedly excessive rates—those generated by patients with premium assistance. It leaves untouched all others. "Such '[u]nderinclusiveness raises serious doubts about whether the government is in fact pursuing the interest it invokes, rather than disfavoring a particular speaker or viewpoint.'" *Id.* (quoting *Brown v. Entertainment Merchants Ass'n*, 564 U.S. 786, 802 (2011)).

Further, as to all the State's potential interests, the Penalty is insufficiently tailored because it sweeps in *all* financial support to AKF. Donations too small or made too long ago to plausibly give rise to steering concerns nonetheless form a "financial relationship." AB290 §3(e)(1). A $10 contribution made ten years ago and a $10 million contribution made yesterday each trigger the same penalty. A financial relationship also is established by donations intended for purposes other than HIPP, such as AKF's lobbying or educational efforts, which have no possible steering effect. The Penalty also reduces reimbursements for all patients who receive HIPP aid, regardless of whether they freely chose private insurance on their own. And that is to say nothing of AB290's burdens on providers and charities

who have nothing to do with dialysis in the first place—a separate constitutional infirmity. *See infra* Part II.

The State has no conceivable interest in burdening all that First Amendment-protected activity. Because AB290 "burden[s] substantially more speech than necessary to achieve the [State's] asserted interests," it does not survive even intermediate scrutiny. *McCullen v. Coakley*, 573 U.S. 464, 490 (2014).

II. THE REIMBURSEMENT PENALTY IS UNCONSTITUTIONALLY OVERBROAD

The Reimbursement Penalty should be enjoined for the further reason that it threatens the First Amendment rights of healthcare providers and charities that do not have even a theoretical connection to the alleged harms that AB290 supposedly addresses. The district court erred in ignoring this fatal defect.

The overbreadth doctrine "requires the invalidation" of a law if there is "a realistic danger that [it] will significantly compromise recognized First Amendment protections of parties not before the Court." *Green v. Miss U.S.A., LLC*, 52 F.4th 773, 800 (9th Cir. 2022) (quoting *Members of City Council v. Taxpayers for Vincent*, 466 U.S. 789, 801 (1984)), *reh'g denied*, 61 F.4th 1095 (9th Cir. 2023); *see also id.* at 800 n.25 (overbreadth "protect[s] the right of association" in addition to speech). Overbreadth "allows a plaintiff 'to challenge a statute because of a judicial prediction or assumption that the statute's very existence may cause others … to refrain from constitutionally protected speech or

expression.'" *Nunez by Nunez v. City of San Diego*, 114 F.3d 935, 949 (9th Cir. 1997); *see also Comite de Jornaleros de Redondo Beach v. City of Redondo Beach*, 657 F.3d 936, 944 (9th Cir. 2011) (en banc) ("admissible evidence of overbreadth" is not required).

Although the Legislature targeted Providers' contributions to AKF in particular, *supra* pp.16-17, 41, it enacted a provision that deters all kinds of healthcare providers from making all kinds of donations to all kinds of premium-assistance charities. It did so by applying the Reimbursement Penalty to (1) any "financially interested [healthcare] provider" that (2) "has a financial relationship with" (3) a "financially interested entity" that makes a "third-party premium payment" to the provider's patient. AB290 §3(e)(1). The statute's exceptionally broad definitions of each of these three terms—specifying who is regulated and under what circumstances—unjustifiably extends the Penalty far beyond the plaintiffs and contributions at issue in this case.

To start, the statute broadly targets—as "financially interested"—virtually any healthcare provider who donates to a charity providing premium assistance.[5] The statute defines "financially interested provider" to include any provider that "receives a direct *or indirect* financial benefit from a third-party premium

[5] The only exception is dialysis clinics that have "no more than 10 percent of California's market share of licensed chronic dialysis clinics." §3(h)(1)(C).

payment." §3(h)(2)(A) (emphasis added). It therefore reaches healthcare providers of all types—general physicians, psychiatrists, allergists, dentists—that provide any type of healthcare to a patient who uses premium assistance from a covered charity. After all, they are "receiv[ing]" an "indirect financial benefit from a third-party premium payment" because they are being paid by a plan that is funded in part through premium assistance. Such providers are thus caught up in AB290, even if they have nothing to do with ESRD and even though they pose no possible threat of the steering the statute allegedly aims to prevent.[6]

The term "financial relationship" amplifies the provision's overbreadth. By its plain terms, it covers any kind of monetary connection.[7] As the district court recognized at the preliminary injunction stage, a covered healthcare provider would thus trigger a qualifying "financial relationship" by merely donating to a covered charity or entering into a charitable contract, like a recurring obligation or bequest, even though such "charitable relationships are protected by the First Amendment." 5-ER-956-957 (citing *Kamerling*, 295 F.3d at 214). Because

[6] AB290 also covers a broad swath of AKF's contributors, including cardiologists and other specialists who do not provide dialysis but treat conditions that often occur with ESRD, like hypertension and diabetes. 4-ER-691.

[7] *See Merriam-Webster's Collegiate Dictionary* 469, "Finance" (11th ed. 2014) ("money or other liquid resources of a government, business, group, or individual"); *id.* at 1050, "Relationship" ("a state of affairs existing between those having relations or dealings").

AB290 sets no minimum amount of value that must be exchanged, any size contribution will do. And, as the district court also recognized, the Penalty "sets no temporal limits, apparently applying to any provider that has *ever* donated to a third-party payer." 5-ER-959.

The statute's broad definition of "financially interested entit[y]" also will ensnare charities beyond AKF. That term "includes" any entity "that receives the majority of its funding from one or more financially interested providers of health care services" or related entities. §3(h)(2)(B). The statute does not identify what else is "included" that might make a charity "financially interested," *id.*, leaving charities uncertain of whether they qualify. Contributors are also in the dark. A pulmonologist buying a ticket to attend a healthcare charity gala almost certainly does not know where that charity receives its funding, but their commendable and innocuous donation could trigger the Reimbursement Penalty. Healthcare providers that wish to avoid AB290's rate cuts will therefore be deterred from contributing to charities that even *might* offer premium assistance, including charities that have no connection whatsoever to ESRD, AKF, or the purported steering that allegedly animates AB290.

Taking these hazardously broad provisions together, there is "a realistic danger," *Green*, 52 F.4th at 800, that the Reimbursement Penalty will significantly chill First Amendment-protected activity. Healthcare providers will be reluctant to

make charitable contributions, lest they see their rates cut on account of that expressive association. And charities may stop providing premium assistance for fear of becoming a covered entity and jeopardizing their funding.

Consider the HealthWell Foundation, a charity that has provided premium assistance to California patients suffering from medical conditions beyond ESRD. 4-ER-697. If HealthWell is financially interested—something donors cannot know—and a California cardiologist donates $100 to HealthWell and later treats a 45-year-old, non-ESRD patient receiving premium assistance from HealthWell, then that doctor will be reimbursed at the lower Medicare rate. The doctor has no incentive or opportunity to steer that patient; indeed, the patient is not even eligible for Medicare because she is too young and has no relevant condition. To avoid that risk, the doctor likely will not donate to HealthWell, abandoning that means of associational support. Charities like HealthWell might stop offering premium assistance to preserve their funding. And patients who rely on HealthWell and similar charities to pay for premiums will suffer the consequences. 4-ER-688; 4-ER-692; 4-ER-697.

The Reimbursement Penalty thus "unnecessarily sweeps a substantial amount of non-disruptive, protected speech within its prohibiting language." *Acosta v. City of Mesa*, 718 F.3d 800, 816 (9th Cir. 2013). That overbreadth—potentially chilling every healthcare provider and every premium-assistance

charity in California—far overshadows the Penalty's "plainly legitimate sweep," if any. *Id.* at 811 (quoting *United States v. Stevens*, 559 U.S. 460, 473 (9th Cir. 2013)). The Court should reverse on that basis alone.

III. ALTERNATIVELY, THE REIMBURSEMENT PENALTY CANNOT BE SEVERED FROM THE UNCONSTITUTIONAL PATIENT DISCLOSURE MANDATE

The Reimbursement Penalty also must be struck down because it is inseverable from another provision, the Patient Disclosure Mandate, that the district court correctly invalidated.

As noted above (at 18), the Patient Disclosure Mandate requires covered charities like AKF to disclose to health insurers the names of patients receiving premium assistance. AB290 §§ 3(c)(2), 5(c)(2). The district court correctly held that the Mandate "violate[s] Plaintiffs' First Amendment right to freedom of association" because the State failed to "explain how the disclosure of patient names to their respective insurers advances a substantial state interest" and because the Mandate was "not sufficiently tailored." *See* 1-ER-54.

After the district court struck down the Patient Disclosure Mandate, the State sought reconsideration, and, in doing so, conceded that without the Mandate, the Reimbursement Penalty cannot "function properly—or even at all." 2-ER-96. That concession is independently fatal to the Reimbursement Penalty, which cannot "'stand on [its] own, unaided by [that] invalid provision[].'" *Vivid Ent., LLC v. Fielding*, 774 F.3d 566, 576 (9th Cir. 2014) (quoting *People's Advocate,*

Inc. v. Superior Court, 226 Cal. Rptr. 640, 649 (App. 1986)). The State's admission—indeed, its affirmative argument—that these two provisions are inextricably intertwined explains why its briefing below failed to dispute Plaintiffs' repeated arguments about inseverability. *See* 5-ER-1124; 5-ER-1027-1028; 4-ER-682; 3-ER-396. The State has thereby waived any such argument. *See, e.g.*, *Comite de Jornaleros*, 657 F.3d at 951 n.10.

The State's concession is correct. A statutory provision can survive only if it is "grammatically," "functionally," and "volitionally" separable from unconstitutional portions of the statute. *Hotel Emps. & Rest. Emps. Int'l Union v. Davis*, 981 P.2d 990, 1010-1011 (Cal. 1999); *see also Garcia v. City of Los Angeles*, 11 F.4th 1113, 1120 (9th Cir. 2021).[8] The Reimbursement Penalty is neither functionally nor volitionally separable from the Patient Disclosure Mandate and therefore cannot survive the Mandate's invalidation.

Functional separability. The State's concession in the district court makes clear that the first requirement for severability is not present. The remaining provisions of a partially unconstitutional statute are functionally separable only if they "'stand on their own, unaided by the invalid provisions nor rendered vague by

[8] AB290 has no severability provision, so there is no "presumption in favor of severance." *California Redevelopment Ass'n v. Matosantos*, 267 P.3d 580, 607 (Cal. 2011).

their absence nor inextricably connected to them by policy considerations. They must be capable of separate enforcement.'" *Garcia*, 11 F.4th at 1120 (quoting *People's Advocate*, 226 Cal. Rptr. at 649). That is not true of the relationship between the Patient Disclosure Mandate and the Reimbursement Penalty.

In upholding the Reimbursement Penalty, the district court stated, without support or explanation, that the Patient Disclosure Mandate "does not affect the enforceability of the remaining statute." 1-ER-66. But the State rightly concedes that it does. In its motion for reconsideration, the State explained that the Patient Disclosure Mandate is "vital for AB 290's [Reimbursement Penalty] to function properly—or even at all." 2-ER-96. The Patient Disclosure Mandate is "critical" and "essential to the [Reimbursement Penalty]'s implementation." 2-ER-91. "Without … disclosures [of patient names], health plans and insurers would have no mechanism to identify the patients for whom the [Reimbursement Penalty] should apply, and thus, the reimbursement cap provisions would effectively be unenforceable." 2-ER-95. The State's "insist[ence] that it could not enforce" the remaining provision without the invalidated provision confirms the district court erred when it concluded otherwise prior to the State's motion for reconsideration. *Garcia*, 11 F.4th at 1123. Because the Penalty is "inextricably connected" to the Patient Disclosure Mandate and is not "capable of separate enforcement," it is not functionally separable. *Vivid*, 774 F.3d at 576. Accordingly, the Reimbursement

Penalty must fall along with the Patient Disclosure Mandate. *Garcia*, 11 F.4th at 1124; *see People v. Library One, Inc.*, 280 Cal. Rptr. 400 (App. 1991) ("Our resolution of this [functional separability] issue obviates any need to address the volitional element….").

Volitional separability. The Reimbursement Penalty also fails the independent requirement that it be volitionally separable from the Patient Disclosure Mandate. A provision is volitionally separable if it "would have been adopted by the legislative body had the [body] foreseen the partial invalidation of the statute." *California Redevelopment*, 267 P.3d at 608 (quoting *Santa Barbara Sch. Dist. v. Superior Court*, 530 P.2d 605, 618 (Cal. 1975)). Volitional separability is particularly unlikely if a provision's enforcement mechanism cannot function without the unconstitutional provision—just as the State conceded is the case here. After all, "[w]hat possible reason could the Legislature have had to pass such a measure if it did not intend that the provision which it authorized was to be enforceable?" *Prieto v. State Farm Mut. Auto. Ins.*, 74 Cal. Rptr. 472, 474 (App. 1969).

The "interwoven" nature of the statutory text confirms the volitional inseparability of the Mandate and Penalty. *Acosta*, 718 F.3d at 818. For example, AB290 instructs that, if a covered charity "fails to provide disclosure pursuant to" the Mandate, the Penalty increases, such that the plan or insurer is "entitled to

recover 120 percent of the" overpayment compared to what would have been paid were disclosure made. § 4(i)(1), 5(i)(1). In the absence of the Mandate, that feature of the Penalty would be deprived of effect.

The district court's conclusory finding of volitional separability got the question backwards. It reasoned that the Mandate was volitionally separable because, "even if the Legislature had foreseen" the Mandate's invalidation, "nothing suggests that they would not have still adopted" those remaining provisions—like the Reimbursement Penalty. 1-ER-66. But California law requires a determination that the Legislature "*would* have separately considered and adopted" the Penalty absent the Patient Disclosure Mandate—a finding that must be made "with confidence." *Acosta*, 718 F.3d at 817-818 (emphasis added) (quoting *Gerken v. Fair Pol. Pracs. Comm'n*, 863 P.2d 694, 699 (Cal. 1993)). The district court made no such finding, much less a confident one, nor could it have done so. The Reimbursement Penalty cannot survive the invalidation of the Patient Disclosure Mandate.

This conclusion of volitional inseparability is reinforced by the fact that the Reimbursement Penalty is just the kind of "[b]road prophylactic rule[]" that is disfavored over "[p]recision of regulation." *Village of Schaumburg*, 444 U.S. at 637. And it is indeed broad. It reaches providers and behavior that bear no connection to the Legislature's central focus on ESRD patients or the harms the

Legislature sought to redress. *Supra* Part II (discussing overbreadth). It is "doubtful," *Acosta*, 718 F.3d at 819, that the Legislature would have wanted only this "suspect" form of regulation, *Village of Schaumburg*, 444 U.S. at 637, to survive in the absence of the original design.

CONCLUSION

The judgment of the district court should be reversed insofar as it held the Reimbursement Penalty constitutional, and the Penalty should be permanently enjoined along with the other provisions of AB290 that the district court properly enjoined.

Respectfully submitted,

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September 23, 2024

CERTIFICATE OF COMPLIANCE

Pursuant to Fed. R. App. P. 32(a)(7)(C), the undersigned hereby certifies that this brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B)(i) and Ninth Circuit Rule 32-2(b).

1. Exclusive of the exempted portions of the brief, as provided in Fed. R. App. P. 32(a)(7)(B), the brief contains 14,562 words.

2. The brief has been prepared in proportionally spaced typeface using Microsoft Word 365 in 14 point Times New Roman font. As permitted by Fed. R. App. P. 32(a)(7)(B), the undersigned has relied upon the word count feature of this word processing system in preparing this certificate.

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September 23, 2024

ADDENDUM OF CONSTITUTIONAL PROVISIONS AND STATUTES

TABLE OF CONTENTS

Page

U.S. Const. amend. I

> Congress shall make no law respecting an establishment of religion, or prohibiting the free exercise thereof; or abridging the freedom of speech, or of the press; or the right of the people peaceably to assemble, and to petition the Government for a redress of grievances.

California Assembly Bill No. 290, Ch. 862, 2019 Cal. Stat. ___

The people of the State of California do enact as follows:

SECTION 1. The Legislature finds and declares as follows:

(a) There has been a rapid increase in the practice of certain health care providers and provider-funded groups paying health insurance premiums in California's individual and group health insurance markets on behalf of consumers with very high-cost conditions such as end stage renal disease and addiction to alcohol or drugs.

(b) These third-party payment arrangements have proliferated in recent years as a result of health care providers that have demonstrated a willingness to exploit the Affordable Care Act's guaranteed issue rules for their own financial benefit.

(c) Encouraging patients to enroll in commercial insurance coverage for the financial benefit of the provider may result in an unjust enrichment of the financially interested provider at the expense of consumers purchasing health insurance. This practice can also expose patients to direct harm.

(d) According to the federal Centers for Medicare and Medicaid Services, patients caught up in these schemes may face higher out-of-pocket costs and mid-year disruptions in coverage, and may have a more difficult time obtaining critical care such as kidney transplants.

(e) Consumers also pay higher health insurance premiums due to the distortion of the insurance risk pool caused when providers steer patients into particular health insurance plans with the promise of having the patients' premiums paid. Nationally, this problem has added billions of dollars of costs to the individual and group health insurance markets.

(f) Certain residential substance use disorder treatment facilities have induced patients to enroll in health insurance with assurances that the treatment center will pay the patients' health insurance premiums. In some cases, patients were not even informed that health insurance was being purchased on their behalf. According to news reports, at the end of their treatment benefit, patients are sometimes stranded far from home and enter a cycle of homelessness.

(g) Large dialysis organizations control 77 percent of California's dialysis clinics, and this market concentration has risen dramatically in recent years. Nationally, the two largest dialysis companies account for 92 percent of all dialysis industry revenue. These companies systematically exert their market dominance to command commercial reimbursement rates that are many times the cost associated with providing care.

(h) Large dialysis companies contribute more than 80 percent of the revenue to a nonprofit that pays health insurance premiums for patients on dialysis for kidney failure. In turn, this nonprofit generates hundreds of millions of dollars for large dialysis organizations by artificially increasing the number of their patients who have commercial insurance coverage.

(i) It is the intent of the Legislature in enacting this act to protect the sustainability of risk pools within the individual and group health insurance markets, shield patients from potential harm caused by being steered into coverage options that may not be in their best interest and to correct a market failure that has allowed large dialysis organizations to use their oligopoly power to inflate commercial reimbursement rates and unjustly drive up the cost of care.

(j) It is the intent of the Legislature that the delayed implementation and conditional nature of certain provisions of this act will allow the American Kidney Fund to request an updated advisory opinion from the United States Department of Health and Human Services Office of Inspector General for the purposes of protecting patients in California.

SEC. 2. Section 1210 is added to the Health and Safety Code, to read:

1210. (a) A chronic dialysis clinic shall not steer, direct, or advise a patient regarding any specific coverage program option or health care service plan contract.

(b) A chronic dialysis clinic shall post a notice in a prominent location visible to all patients displayed in large font type that questions about Medicare coverage for patients with end stage renal disease should be directed to the Health Insurance Counseling and Advocacy Program or HICAP at 1-800-434-0222.

SEC. 3. Section 1367.016 is added to the Health and Safety Code, to read:

1367.016. (a) A health care service plan shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full plan year and notify the enrollee prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable. Assistance may be discontinued at the request of an enrollee who obtains other health coverage, or if the enrollee dies during the plan year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform a recipient annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the patient into or away from a specific coverage program option or health care service plan contract.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health care service plan that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health care service plan, prior to making the initial payment, the name of the enrollee for each health care service plan contract on whose behalf a third-party premium payment described in this section will be made.

(d) (1) Reimbursement for enrollees for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those enrollees.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an enrollee on whose behalf the financially interested entity was making premium payments to a health care service plan on the enrollee's behalf prior to October 1, 2019, if the enrollee changes health care service plans on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the enrollee's health care service plan contract, except for an enrollee who has changed health care service plans pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health care service plan on behalf of an enrollee, reimbursement to a provider who is also a financially interested entity for covered services provided shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be the higher of the Medicare reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the enrollee shall be governed by the terms and conditions of the enrollee's health care service plan contract or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health care service plan. Financially interested providers shall neither bill the enrollee nor seek reimbursement from the enrollee for services provided, except for cost sharing pursuant to the terms and conditions of the enrollee's health care service plan contract. If an enrollee's contract imposes a coinsurance payment for a claim that is subject to this paragraph, the

coinsurance payment shall be based on the amount paid by the health care service plan pursuant to this paragraph. A claim submitted to a health care service plan by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health care service plan pursuant to Section 1371 or 1371.35 if the financially interested provider has not provided the information as required in subdivision (c).

(f) (1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health care service plan submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health care service plan shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the plan year for that enrollee. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same plan or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple enrollees from the same provider to the same health care service plan to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 1374.32.

(10) The department may contract with the same independent organization or organizations as the Department of Insurance.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health care service plan's obligations under Section 1371.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by means of all-plan letters or similar instructions, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health care service plan premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health care service plan premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health care service plan premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Enrollee" means an individual whose health care service plan premiums are paid by a financially interested entity.

(2) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(3) "Health care service plan contract" means an individual or group health care service plan contract that provides medical, hospital, and surgical benefits, except a specialized health care service plan contract. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, long-term care insurance, coverage issued as a supplement to liability insurance, insurance arising out of workers' compensation law or similar law, automobile medical payment insurance, or insurance under which benefits are payable with or without regard to fault and that is statutorily required to be contained in any liability insurance policy or equivalent self-insurance.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health care service plan subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health care service plan shall be entitled to recover 120 percent of the difference between a payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health care service plan shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health care service plan licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (e). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health care service plan's knowledge, the number of enrollees whose premiums were paid by financially interested entities, disclosures provided to the plan pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(l) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health care service plan's obligations and requirements under this chapter, including, but not limited to, the following:

(1) The obligation of a health care service plan to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any

individual, consistent with Article 11.8 (commencing with Section 1399.845), or small employer, consistent with Article 3.1 (commencing with Section 1357).

(2) The obligations of a health care service plan with respect to cancellation or nonrenewal as provided in this chapter, including, but not limited to, Section 1365.

(3) A health care service plan may not deny coverage to an enrollee whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849, an enrollee's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 1399.849.

SEC. 4. Section 1385.09 is added to the Health and Safety Code, to read:

1385.09. A health care service plan contract subject to Section 1385.03 or 1385.04 shall file a separate schedule documenting the cost savings associated with Section 1367.016 and the impact on rates.

SEC. 5. Section 10176.11 is added to the Insurance Code, to read:

10176.11. (a) An insurer that provides a policy of health insurance shall accept premium payments from the following third-party entities without the need to comply with subdivision (c):

(1) A Ryan White HIV/AIDS Program under Title XXVI of the federal Public Health Service Act.

(2) An Indian tribe, tribal organization, or urban Indian organization.

(3) A local, state, or federal government program, including a grantee directed by a government program to make payments on its behalf.

(4) A member of the individual's family, defined for purposes of this section to include the individual's spouse, domestic partner, child, parent, grandparent, and siblings, unless the true source of funds used to make the premium payment originates with a financially interested entity.

(b) A financially interested entity that is not specified in subdivision (a) and is making third-party premium payments shall comply with all of the following requirements:

(1) It shall provide assistance for the full policy year and notify the insured prior to an open enrollment period, if applicable, if financial assistance will be discontinued. Notification shall include information regarding alternative coverage options, including, but not limited to, Medicare, Medicaid, individual market policies, and employer policies, if applicable. Assistance may be discontinued at the request of an insured who obtains other health insurance coverage, or if the insured dies during the policy year.

(2) It shall agree not to condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device.

(3) It shall inform an applicant of financial assistance, and shall inform an insured annually, of all available health coverage options, including, but not limited to, Medicare, Medicaid, individual market plans, and employer plans, if applicable.

(4) It shall agree not to steer, direct, or advise the insured into or away from a specific coverage program option or health coverage.

(5) It shall agree that financial assistance shall not be conditioned on the use of a specific facility, health care provider, or coverage type.

(6) It shall agree that financial assistance shall be based on financial need in accordance with criteria that are uniformly applied and publicly available.

(c) A financially interested entity shall not make a third-party premium payment unless the entity complies with both of the following requirements:

(1) Annually provides a statement to the health insurer that it meets the requirements set forth in subdivision (b), as applicable.

(2) Discloses to the health insurer, prior to making the initial payment, the name of the insured for each policy on whose behalf a third-party premium payment described in this section will be made.

(d) (1) Reimbursement for insureds for whom a nonprofit financially interested entity described in paragraph (2) of subdivision (h) that was already making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, is not subject to subdivisions (e) and (f) and the financially interested entity is not required to comply with the disclosure requirements described in subdivision (c) for those insureds.

(2) Notwithstanding paragraph (1), a financially interested entity shall comply with the disclosure requirements of subdivision (c) for an insured on whose behalf the financially interested entity was making premium payments to a health insurer on the insured's behalf prior to October 1, 2019, if the insured changes health insurers on or after March 1, 2020.

(3) The amount of reimbursement for services paid to a financially interested provider shall be governed by the terms of the insured's health insurance policy contract, except for an insured who has changed health insurers pursuant to paragraph (2), in which case, commencing January 1, 2022, the reimbursement amount shall be determined in accordance with subdivisions (e) and (f).

(e) Commencing January 1, 2022, if a financially interested entity makes a third-party premium payment to a health insurer on behalf of an insured, reimbursement to a financially interested provider for covered services shall be determined by the following:

(1) For a contracted financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the higher of the Medicare

reimbursement or the rate determined pursuant to the process described in this subdivision, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall neither bill the insured nor seek reimbursement from the insured for services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If an insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph.

(2) For a noncontracting financially interested provider that makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement for covered services that shall be paid to the financially interested provider on behalf of the insured shall be governed by the terms and conditions of the insured's health insurance policy or the rate determined pursuant to the process described in this subdivision, whichever is lower, if a rate determination pursuant to that process is sought by either the provider or the health insurer. Financially interested providers shall not bill the insured nor seek reimbursement from the insured for services provided, except for cost sharing pursuant to the terms and conditions of the insured's health insurance policy. If the insured's policy imposes a coinsurance payment for a claim that is subject to this paragraph, the coinsurance payment shall be based on the amount paid by the health insurer pursuant to this paragraph. A claim submitted to a health insurer by a noncontracting financially interested provider may be considered an incomplete claim and contested by the health insurer pursuant to Section 10123.13 or 10123.147 if the financially interested provider has not provided the information as required in subdivision (c).

(f) (1) By October 1, 2021, the department shall establish an independent dispute resolution process for the purpose of determining if the amount required to be reimbursed by subdivision (e) is appropriate.

(2) If either the provider or health insurer submits a claim to the department's independent dispute resolution process, the other party shall participate in the independent dispute resolution process.

(3) In making its determination, the independent organization shall consider information submitted by either party regarding the actual cost to

provide services, patient eligibility for Medicare or Medi-Cal, and the rate that would be paid by Medicare or Medi-Cal for patients eligible for those programs.

(4) The health insurer shall implement the determination obtained through the independent dispute resolution process. The independent organization's determination of the amount required to be reimbursed shall apply for the duration of the policy year for that insured. If dissatisfied, either party may pursue any right, remedy, or penalty established under any other applicable law.

(5) In establishing the independent dispute resolution process, the department shall permit the bundling of claims submitted to the same insurer or the same delegated entity for the same or similar services. The department shall permit claims on behalf of multiple insureds from the same provider to the same health insurer to be combined into a single independent dispute resolution process.

(6) The department shall establish uniform written procedures for the submission, receipt, processing, and resolution of claim payment disputes pursuant to this section and any other guidelines for implementing this section.

(7) The department shall establish reasonable and necessary fees not to exceed the reasonable costs of administering this subdivision.

(8) The department may contract with one or more independent organizations to conduct the proceedings. The independent organization handling a dispute shall be independent of either party to the dispute.

(9) The department shall use conflict-of-interest standards consistent with the standards pursuant to subdivisions (c) and (d) of Section 10169.2.

(10) The department may contract with the same independent organization or organizations as the Department of Managed Health Care.

(11) The independent organization retained to conduct proceedings shall be deemed to be consultants for purposes of Section 43.98 of the Civil Code.

(12) Contracts entered into pursuant to the authority in this subdivision shall be exempt from Part 2 (commencing with Section 10100) of Division 2 of the Public Contract Code, Section 19130 of the Government Code, and Chapter 6 (commencing with Section 14825) of Part 5.5 of Division 3 of Title 2 of the Government Code, and shall be exempt from the review or approval of any division of the Department of General Services.

(13) This subdivision does not alter a health insurer's obligations under Section 10123.13.

(14) Notwithstanding Chapter 3.5 (commencing with Section 11340) of Part 1 of Division 3 of Title 2 of the Government Code, the department may implement, interpret, or make specific this section by issuing guidance, without taking regulatory action, until regulations are adopted.

(g) For the purposes of this section, third-party premium payments only include health insurance premium payments made directly by a provider or other third party, made indirectly through payments to the individual for the purpose of making health insurance premium payments, or provided to one or more intermediaries with the intention that the funds be used to make health insurance premium payments for the individuals.

(h) The following definitions apply for purposes of this section:

(1) "Financially interested" includes any of the following entities:

(A) A provider of health care services that receives a direct or indirect financial benefit from a third-party premium payment.

(B) An entity that receives the majority of its funding from one or more financially interested providers of health care services, parent companies of providers of health care services, subsidiaries of health care service providers, or related entities.

(C) A chronic dialysis clinic that is operated, owned, or controlled by a parent entity or related entity that meets the definition of a large dialysis clinic organization (LDO) under the federal Centers for Medicare and Medicaid Services Comprehensive ESRD Care Model as of January 1, 2019. A chronic dialysis clinic that does not meet the definition of an LDO or has no more than 10 percent of

California's market share of licensed chronic dialysis clinics shall not be considered financially interested for purposes of this section.

(2) "Health insurance" means an individual or group health insurance policy as defined in subdivision (b) of Section 106. The term does not include coverage of Medicare services pursuant to contracts with the United States government, Medicare supplement coverage, or specialized health insurance coverage as described in subdivision (c) of Section 106.

(3) "Insured" means an individual whose health insurance premiums are paid by a financially interested entity.

(4) "Provider" means a professional person, organization, health facility, or other person or institution that delivers or furnishes health care services.

(i) The following shall occur if a health insurer subsequently discovers that a financially interested entity fails to provide disclosure pursuant to subdivision (c):

(1) The health insurer shall be entitled to recover 120 percent of the difference between payment made to a provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference.

(2) The health insurer shall notify the department of the amount by which the provider was overpaid and shall remit to the department any amount exceeding the difference between the payment made to the provider and the payment to which the provider would have been entitled pursuant to subdivision (e), including interest on that difference that was recovered pursuant to paragraph (1).

(j) Commencing January 1, 2022, each health insurer licensed by the department and subject to this section shall provide to the department information regarding premium payments by financially interested entities and reimbursement for services to providers under subdivision (d). The information shall be provided at least annually at the discretion of the department and shall include, to the best of the health insurer's knowledge, the number of insureds whose premiums were paid by financially interested entities, disclosures provided to the insurer pursuant to subdivision (c), the identities of any providers whose reimbursement rate was governed by subdivision (e), the identities of any providers who failed to provide

disclosure as described in subdivision (c), and, at the discretion of the department, additional information necessary for the implementation of this section.

(k) This section does not limit the authority of the Attorney General to take action to enforce this section.

(l) This section does not affect a contracted payment rate for a provider who is not financially interested.

(m) This section does not alter any of a health insurer's obligations and requirements under this part, including, but not limited to, the following:

(1) The obligation of a health insurer to fairly and affirmatively offer, market, sell, and issue a health benefit plan to any individual, consistent with Chapter 9.9 (commencing with Section 10965), or small employer, consistent with Chapter 8 (commencing with Section 10700).

(2) The obligations of a health insurer with respect to cancellation or nonrenewal as provided in this part, including, but not limited to, Sections 10273.4, 10273.6, and 10273.7.

(3) A health insurer may not deny coverage to an insured whose premiums are paid by a third party.

(n) This section does not supersede or modify any privacy and information security requirements and protections in federal and state law regarding protected health information or personally identifiable information, including, but not limited to, the federal Health Insurance Portability and Accountability Act of 1996 (42 U.S.C. Sec. 300gg).

(o) Notwithstanding clause (iii) of subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3, an insured's loss of coverage due to a financially interested entity's failure to pay premiums on a timely basis shall be deemed a triggering event for special enrollment pursuant to subparagraph (A) of paragraph (1) of subdivision (d) of Section 10965.3.

SEC. 6. Section 10181.8 is added to the Insurance Code, to read:

10181.8. A health insurance policy subject to Section 10181.3 or 10181.4 shall file a separate schedule documenting the cost savings associated with Section 10176.11 and the impact on rates.

SEC. 7. For financially interested entities covered by Advisory Opinion No. 97-1 issued by the United States Department of Health and Human Services Office of Inspector General, Sections 3 to 6, inclusive, of this act shall become operative on July 1, 2020, unless one or more parties to Advisory Opinion 97-1 requests an updated opinion from the United States Department of Health and Human Services Office of Inspector General and notifies the Department of Managed Health Care and the Department of Insurance of that request, in writing, including a copy of the request. If the notification and copy of the request are received by the departments prior to July 1, 2020, Sections 3 to 6, inclusive, of this act shall become operative with respect to those entities upon a finding by the United States Department of Health and Human Services Office of Inspector General, in accordance with Section 1128D(b) of the federal Social Security Act (42 U.S.C. Sec. 1320a-7d(b)) and Part 1008 (commencing with Section 1008.1) of Subchapter B of Chapter V of Title 42 of the Code of Federal Regulations, that compliance with those sections by a financially interested entity does not violate the federal laws addressed by Advisory Opinion 97-1 or a successor agreement. Each department shall post any notice received pursuant to this section and a copy of the request on its internet website.

SEC. 8. No reimbursement is required by this act pursuant to Section 6 of Article XIIIB of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIIIB of the California Constitution.

CERTIFICATE OF SERVICE

I hereby certify that on this 23rd day of September, 2024, I electronically filed the foregoing with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit using the appellate CM/ECF system. Counsel for all parties to the case are registered CM/ECF users and will be served by the appellate CM/ECF system.

/s/ Ari Holtzblatt
ARI HOLTZBLATT

Counsel for Plaintiff-Appellant DaVita Inc.

CIRCUIT RULE 25-5 ATTESTATION

I attest that all Plaintiffs-Appellants concur in the content of this filing.

/s/ Ari Holtzblatt
ARI HOLTZBLATT

Counsel for Plaintiff-Appellant
DaVita Inc.