No. 24-3654, 24-3655, 24-3700

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

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

and

JANE DOE, *et al.*,
Plaintiffs, Appellants, and Cross Appellees,

v.

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

On Appeal from the United States District Court
for the Central District of California
Nos. 19-cv-2105, 19-cv-2130
Hon. David O. Carter, District Judge

APPELLEES' AND CROSS-APPELLANTS' PRINCIPAL AND RESPONSE BRIEF

ROB BONTA
Attorney General of California
MICHAEL J. MONGAN
Solicitor General
HELEN H. HONG
Principal Deputy Solicitor General
THOMAS S. PATTERSON
Senior Assistant Attorney General
R. MATTHEW WISE
Supervising Deputy Attorney General

*JOSHUA PATASHNIK
Deputy Solicitor General
LISA J. PLANK
S. CLINTON WOODS
Deputy Attorneys General

CALIFORNIA DEPARTMENT OF JUSTICE
600 West Broadway, Suite 1800
San Diego, CA 92101
(619) 738-9628
josh.patashnik@doj.ca.gov

Attorneys for Defendants, Appellees, and Cross-Appellants

December 2, 2024

TABLE OF CONTENTS

Page

TABLE OF CONTENTS
(continued)

Page

TABLE OF AUTHORITIES

Page

CASES

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

TABLE OF AUTHORITIES
(continued)

Page

STATUTES

TABLE OF AUTHORITIES
(continued)

Page

REGULATIONS

COURT RULES

INTRODUCTION

Dialysis offers vital, life-saving treatment to patients suffering from end-stage renal disease (ESRD). But it is an extremely expensive form of care, and funding dialysis treatment for the patients who need it presents a serious challenge for both public health insurance programs and commercial insurance plans. Medicare and Medi-Cal (California's version of the federal Medicaid program) offer dialysis coverage to patients while controlling costs by negotiating favorable rates. Commercial insurance plans reimburse dialysis providers at a significantly higher rate for the same care—about $100,000 more per patient per year.

Since 2014, the federal Affordable Care Act has generally prohibited commercial insurers from denying coverage or charging higher premiums to patients with preexisting conditions like ESRD. That statutory change and other developments opened the commercial insurance market to ESRD patients. At the same time, it created a financial opportunity for major dialysis providers: by subsidizing the commercial insurance premiums of patients previously covered by Medicare or Medi-Cal, they could obtain hundreds of millions of dollars in elevated reimbursement rates each year, well in excess of the cost of the subsidies.

That windfall for dialysis providers comes at a cost to the public. Because ESRD patients have very high healthcare costs, an influx of such patients into

commercial insurance plans adversely affects the risk mix of those plans, leading to an increase in premiums for all enrollees.

That concern, among others, led the California Legislature to enact AB 290. The Legislature found that dialysis providers' efforts to shift ESRD patients into commercial insurance plans threatened to unjustly enrich those providers at the expense of enrollees in commercial insurance plans, who would face higher premiums as a result. AB 290 thus imposes a set of requirements on dialysis providers and affiliated entities such as the American Kidney Fund (AKF)—a charity that receives the vast majority of its funding from providers, with an understanding that those funds will be used to subsidize commercial insurance premiums of the providers' patients. AB 290 specifies that when providers or entities like AKF subsidize a patient's insurance premiums, the reimbursement rate a provider may obtain is limited to either the Medicare rate or a rate determined under an independent dispute-resolution process established by state regulators.

The district court upheld the reimbursement cap and several of AB 290's other provisions, and its judgment on those issues should be affirmed. Plaintiffs argue that the reimbursement cap burdens their First Amendment right of expressive association by penalizing them for their charitable contributions to AKF. It does not; it regulates the business conduct of providers and their affiliated entities. While charitable contributions may often be expressive for First

Amendment purposes, a reasonable observer would not perceive providers' contributions to AKF to have any meaningful expressive content. As the district court reasoned, those contributions serve instead as a financial tool for providers to increase their own revenue—by facilitating a shift of patients from Medicare and Medi-Cal to commercial insurance plans—in an amount that far exceeds providers' contributions. And even if the reimbursement cap does incidentally burden providers' expression, it is nonetheless lawful under well-established First Amendment principles because it advances the State's substantial interest in preventing the unjust enrichment of dialysis providers and protecting patients and the commercial health insurance market. The reimbursement cap is also appropriately tailored to these goals: it leaves providers free to speak as they see fit, instead limiting the financial incentive for them to secure elevated reimbursement rates by shifting patients into commercial insurance plans.

The district court properly rejected most of plaintiffs' other claims, but it erred in two respects in invalidating discrete provisions of AB 290 under the First Amendment. The statute prohibits entities like AKF from conditioning financial assistance to a patient on a specific course of treatment. That is a typical consumer-protection measure that prevents undue influence on a patient's personal healthcare decisions, not a restriction on AKF's speech or expression. And AB 290's requirement that entities like AKF disclose to health insurers the names of

patients receiving premium support is a modest commercial disclosure provision that will allow insurers to confirm that dialysis providers are abiding by the reimbursement cap. The district court's judgment on those two issues should be reversed.

JURISDICTIONAL STATEMENT

The district court had jurisdiction over plaintiffs' federal constitutional claims under 28 U.S.C. § 1331. On May 9, 2024, the district court issued a final judgment and permanent injunction barring the enforcement of certain provisions of AB 290, while entering judgment in favor of defendants on other claims. 1-PER-3-7.[1] Plaintiffs timely filed a notice of appeal on June 7, 2024; defendants timely filed a notice of appeal on June 12, 2024. 2-PER-71-85. This Court has jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

1. Whether the district court correctly concluded that:

    a. AB 290's reimbursement cap does not violate the First Amendment.

[1] "PER" refers to the excerpts of record filed by the provider plaintiffs (Fresenius Medical Care Orange County, LLC et al.) in No. 24-3654 (9th Cir.), docket numbers 27.1 through 27.6.

b. AB 290's requirement that a financially interested entity inform patients of all available health coverage options does not violate the First Amendment.

c. AB 290 does not conflict with federal statutory law or the Petition Clause of the First Amendment.

2. Whether the district court erred in concluding that:

a. AB 290's prohibition on conditioning financial assistance to patients on a specific course of treatment violates the First Amendment.

b. AB 290's patient disclosure requirement violates the First Amendment.

ADDENDUM OF STATUTORY PROVISIONS

Pertinent statutory provisions are reproduced in the addendum that follows Fresenius's opening brief, docket entry 28.1. *See* 9th Cir. R. 28-2.7.

STATEMENT OF THE CASE

A. Factual Background

End-stage renal disease occurs when a patient's kidneys are no longer able to filter waste from the blood. 2-PER-119. The disease is irreversible and permanent, and patients suffering from it require either a kidney transplant or regular dialysis to survive. 2-PER-121. For some patients, dialysis is the only viable treatment option, either because no kidney is available for transplant or

because the patient is medically unsuited for a transplant. 1-PER-18; 2-PER-121. DaVita Inc. (DaVita) and Fresenius Medical Care Holdings, Inc. (Fresenius), who are plaintiffs in this litigation, are by far the two largest dialysis providers in the United States, with a combined market share of more than 70 percent. *See* 1-SER-138.

Dialysis is both a costly and time-intensive treatment, making it difficult for many ESRD patients to maintain employment and obtain employer-sponsored commercial health insurance. 1-PER-18; 2-PER-121. As a result, many receive government-funded health insurance. Since 1972, ESRD patients have been eligible for Medicare coverage regardless of their age. 1-PER-18; 1-SER-4-5. Other patients qualify for and receive coverage through Medi-Cal (California's Medicaid program) or through a combination of Medicare and Medi-Cal. 1-PER-18-19; 1-SER-6. In addition, for many years, commercial insurance companies declined to cover ESRD patients, but the so-called "guaranteed issue" provision of the 2010 Patient Protection and Affordable Care Act now generally prohibits insurers from denying coverage or charging higher premiums to ESRD patients. 1-PER-20; 1-SER-6-7.

That change in the law and other developments created a financial opportunity for dialysis providers such as DaVita and Fresenius. Providers receive significantly higher reimbursement rates—on the order of $100,000 more per

patient per year—for patients with commercial insurance than for those with Medicare or Medi-Cal. 1-PER-20, 49-50; 1-SER-54-55, 122. As a result, providers have a significant and undisputed financial incentive to steer patients into commercial insurance plans and away from Medicare or Medi-Cal. 1-PER-20; 1-SER-7-8.

Plaintiff American Kidney Fund, Inc. (AKF) is a 501(c)(3) nonprofit entity that exists in large part to facilitate that effort. 1-PER-19. As the district court explained, "[b]ecause a host of laws, regulations, and other authorities prohibit providers from paying their own patients' premiums," providers like DaVita and Fresenius "work with AKF as a financial intermediary through which the provider effectively pays its patients' premiums" without violating the law. 1-PER-49; *see* 1-SER-56-58. Approximately 80 percent of AKF's funding comes from DaVita and Fresenius in the form of so-called "fair share" contributions—contributions without which AKF could not afford to pay patients' commercial insurance premiums. 1-PER-40-50; 1-SER-56-58, 76, 169-170, 201. These contributions are "calibrated to cover the amounts in premiums . . . patients would require for commercial insurance premiums." 1-PER-49; *see* 1-SER-65, 169, 175. Providers and AKF "operate under an understanding that AKF will route . . . much of the 'donations' back to the providers' patients in amounts calculated to cover their

premiums" through AKF's Health Insurance Premium Program (HIPP). 1-PER-49; *see* 1-SER-66, 214.

As the district court found, "[b]y funneling money through AKF and back to its patients, the providers are essentially paying their patients to enroll in . . . commercial insurance plans" so that providers may "reap the reimbursement rates for commercial coverage, which are considerably higher than for public coverage." 1-PER-49. "For a time, AKF even made the transactional nature of this arrangement even more explicit by requesting that an organization not refer patients to the HIPP program if the company could not make fair share contributions." 1-PER-50; *see* 1-SER-57-58, 170, 175.

The U.S. Department of Health and Human Services (HHS) became concerned that DaVita, Fresenius, and other providers were inappropriately "encouraging individuals to make coverage decisions based on the financial interest of the health care provider, rather than the best interests of the individual patients." 1-PER-20; 1-SER-9. The evidence "suggested that this inappropriate steering of patients may be accelerating over time" and was harming patients in several ways—such as exposing them to increased costs and disruptions in care and making it more difficult for some patients to meet the financial requirements for obtaining a kidney transplant. 1-PER-21; 1-SER-13-15. In 2016, to address these concerns, the Centers for Medicare and Medicaid Services (CMS) issued an

interim final rule that (among other things) required dialysis providers to disclose to patients their contributions to AKF and similar organizations, and allowed insurers to refuse premium assistance payments from such organizations. *See* Medicare Program; Conditions for Coverage for End-Stage Renal Disease Facilities—Third Party Payment, 81 Fed. Reg. 90211, 90219-20 (Dec. 14, 2016). A federal district court preliminarily enjoined the rule on the grounds that it was arbitrary and capricious, and that CMS had promulgated it without notice and comment. *Dialysis Patient Citizens v. Burwell*, No. 17-cv-16, 2017 WL 365271, at *2-6 (E.D. Tex. Jan. 25, 2017). CMS did not appeal that ruling or seek to reissue the rule.

B. Assembly Bill 290

In the absence of federal action, several States took steps to regulate dialysis providers. 1-SER-17. In 2019, the California Legislature enacted AB 290 to address harms similar to those that had motivated the CMS rulemaking. 2019 Cal. Stat. ch. 862 (hereafter AB 290).[2] In so doing, the Legislature made detailed findings regarding the effects of dialysis providers' steering practices. It found that dialysis providers, working through AKF as an intermediary, were subsidizing patients' commercial insurance premiums to "exploit the Affordable Care Act's

[2] The text of AB 290 appears in the addendum following Fresenius's opening brief in this Court, docket number 28.1.

guaranteed issue rules for their own financial benefit." *Id.* § 1(a)-(b). This practice threatened to "result in an unjust enrichment of the financially interested provider at the expense of consumers purchasing health insurance." *Id.* § 1(c). "Consumers . . . pay higher health insurance premiums due to the distortion of the insurance risk pool caused when providers steer patients" with ESRD into commercial health insurance plans, "add[ing] billions of dollars of costs to the individual and group health insurance markets." *Id.* § 1(e). The providers' steering practices also "expose patients to direct harm," including "higher out-of-pocket costs," "mid-year disruptions in coverage," and "a more difficult time obtaining critical care such as kidney transplants." *Id.* § 1(c)-(d).

AB 290 includes several provisions aimed at protecting patients and consumers from these harms. It imposes a variety of restrictions and obligations on "financially interested" entities, which the statute defines to include any entity that receives a "direct or indirect financial benefit from a third-party premium payment" as well as any entity "that receives the majority of its funding from one or more financially interested providers of health care services" or their parent or subsidiary companies. AB 290 §§ 3(h)(2), 5(h)(1).[3] It is undisputed that DaVita,

[3] Most of AB 290's operative provisions are in Section 3 of the statute, which is codified at California Health & Safety Code § 1367.016, and in Section 5 of the statute, which is codified at California Insurance Code § 10176.11. Many of the (continued…)

Fresenius, and AKF fall within the statute's definition of financially interested entities. *See* 1-PER-22.

AB 290 generally requires any "financially interested entity" that "is making third-party premium payments" to comply with several requirements. *See generally* AB 290 §§ 3(b)-(c), 5(b)-(c). It may not "condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device," *id.* §§ 3(b)(2), 5(b)(2), nor may it "steer, direct, or advise the patient into or away from" any health insurance coverage option, *id.* §§ 3(b)(4), 5(b)(4); *see also id.* § 2(a). The financially interested entity must "provide assistance for the full plan year and notify the enrollee prior to an open enrollment period . . . if financial assistance will be discontinued." *Id.* §§ 3(b)(1), 5(b)(1). It must also "inform" patients "of all available health coverage options, including, but not limited to, Medicare [and] Medicaid," *id.* §§ 3(b)(3), 5(b)(3), and must "disclose[]" to insurers "the name of [each] enrollee . . . on whose behalf a third-party premium payment" is made, *id.* §§ 3(c)(2), 5(c)(2).

---

provisions of Section 3 and Section 5 mirror each other. Broadly speaking, Section 3 applies to health care service plans regulated by the California Department of Managed Health Care, *see* Cal. Health & Saf. Code § 1341, and Section 5 applies to insurers regulated by the California Department of Insurance and the Insurance Commissioner, *see* Cal. Ins. Code § 12921. This brief uses the terms "plans" and "insurers" interchangeably to refer to both sets of entities.

The statute also limits the reimbursement rates that any "provider who is also a financially interested entity" may receive from insurers for patients who are the beneficiaries of third-party premium payments. AB 290 § 3(e); *see also id.* § 5(e). As a general matter, if a "financially interested provider . . . makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment, the amount of reimbursement" paid to the provider "shall be the higher of" (1) "the Medicare reimbursement" rate or (2) a "rate determined pursuant to" an "independent dispute resolution process" to be established by the Department of Managed Health Care (under Section 3) or the Department of Insurance (under Section 5). *Id.* §§ 3(e)(1), 3(f)(1), 5(e)(1), 5(f)(1).

While the Legislature was considering whether to enact AB 290, AKF voiced a concern that the statute as drafted would violate the federal Beneficiary Inducement Statute, 42 U.S.C. § 1320a-7a, and Advisory Opinion 97-1, a guidance document issued by the HHS Office of the Inspector General. *See* 1-PER-31; 1-SER-104-112. In AKF's view, AB 290 would cause recipients of third-party premium support to learn of their provider's contributions to AKF—potentially in violation of the Beneficiary Inducement Statute, which generally prohibits offering "remuneration to any individual eligible for benefits" under Medicare or Medicaid to influence the individual's choice of healthcare provider. 42 U.S.C. § 1320a-7a(a)(5). Advisory Opinion 97-1 expressed the HHS Inspector General's

conclusion that the arrangement between dialysis providers and AKF did not violate that statute so long as certain safeguards were implemented. 1-PER-32-33; 4-PER-772-79.

To address AKF's concern, Section 7 of AB 290 provides a mechanism to ensure that financially interested entities' compliance with the state statute does not violate federal law. It specifies that if one or more financially interested entities were to request an "updated opinion" from the HHS Inspector General, the effective date of AB 290's principal operative provisions (July 1, 2020) would be delayed until the HHS Inspector General were to make a "finding" that "compliance" with the statute "by a financially interested entity does not violate the federal laws addressed by Advisory Opinion 97-1." AB 290 § 7. No financially interested entity ever requested such an opinion.

C. Procedural History

In November 2019, two sets of plaintiffs sued in federal court seeking to enjoin the operation of several provisions of AB 290. The plaintiffs in the first action (*Doe*) include two ESRD patients; AKF; and Dialysis Patient Citizens, Inc., a 501(c)(4) nonprofit organization. 8-AKF-ER-1733. The plaintiffs in the second action (*Fresenius*) include DaVita and Fresenius; an affiliate of Fresenius that operates dialysis clinics in Orange County, California; and U.S. Renal Care, Inc., which is the third-largest dialysis provider in the country behind DaVita and

Fresenius. 5-PER-1095-96. The defendants in both cases are state officials with responsibility for implementing and enforcing AB 290. 8-AKF-ER-1734; 5-PER-1096-97.

Plaintiffs in both cases alleged a number of federal constitutional claims. They argued that several provisions in AB 290 violate their First Amendment rights to speech and association. 8-AKF-ER-1760-62; 5-PER-1121-24. They contended that federal law preempts AB 290 under the Supremacy Clause in certain respects. 8-AKF-ER-1757-59; 5-PER-1124-28. And the *Fresenius* plaintiffs alleged claims under the Contracts Clause, Due Process Clause, and Takings Clause of the U.S. Constitution. 5-PER-1128-34.

Both sets of plaintiffs sought preliminary injunctions, which the district court granted. 5-PER-948-64. It concluded that plaintiffs were likely to succeed on the merits of their First Amendment challenge to Sections 3(b)(4) and 5(b)(4) of AB 290, which provide that financially interested entities may not "steer, direct, or advise the patient into or away from" any health insurance coverage option. 5-PER-953-56. The court also determined that plaintiffs had "raised serious questions on the merits of their First Amendment challenge" to AB 290's provisions limiting reimbursement rates paid to providers for patients receiving third-party premium assistance. 5-PER-956. Applying California law severability

principles, the court preliminarily enjoined the statute in its entirety. 5-PER-959-61.

The district court consolidated the two cases, *see* 1-PER-23, and the parties each filed summary judgment motions. The court ruled in plaintiffs' favor in certain respects and in defendants' favor in others.

Reimbursement cap: The district court rejected plaintiffs' argument that AB 290's limitations on provider reimbursement, *see* §§ 3(e), 5(e), violate their First Amendment rights of association. 1-PER-48-51. It agreed with the State's argument that the reimbursement cap is "a restriction on economic activity" rather than expressive conduct. 1-PER-49. The court reasoned that providers' contributions to AKF "are not an expressive avenue" but rather "a quid pro quo arrangement that secures a later return on investment in the form of higher private insurance reimbursements." *Id.* (internal quotation marks and alterations omitted); *accord* 1-PER-50 (noting the "transactional nature of the relationship between AKF" and providers). The court credited the Legislature's finding that the "hundreds of millions of dollars" providers receive in elevated reimbursement rates "by artificially increasing the number of their patients who have commercial insurance coverage . . . unjustly drive up the cost of care" for patients. 1-PER-51.

Disclosure provisions: The district court upheld AB 290's requirement that financially interested entities inform patients of "all available health coverage

options," including Medicare and Medicaid. 1-PER-54-56; *see* AB 290 §§ 3(b)(3), 5(b)(3). Applying the framework for commercial disclosures set forth in *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985), the court reasoned that these provisions require disclosure of "purely factual and uncontroversial" information that is "reasonably related to a substantial governmental interest." 1-PER-56. But the district court concluded that a separate requirement that financially interested entities "disclose[]" to insurers "the name of [each] enrollee . . . on whose behalf a third-party premium payment" is made, AB 290 §§ 3(c)(2), 5(c)(2), violated plaintiffs' First Amendment rights of association. 1-PER-53-54.

Preemption: The district court rejected plaintiffs' claims that federal statutory law preempts AB 290. Plaintiffs had argued that AB 290's disclosure and reimbursement provisions would result in "patients finding out whether their providers donate to AKF," 1-PER-33, which plaintiffs contended violates the Beneficiary Inducement Statute, 42 U.S.C. § 1320a-7a, as interpreted by Advisory Opinion 97-1, *see supra* at 12-13. The court disagreed, finding "no evidence" to support plaintiffs' theory, and further explained that even if patients were to ascertain whether their provider had donated to AKF, they would do so only after they had "already . . . chosen a provider without undue influence," which is the core concern of Advisory Opinion 97-1. 1-PER-34. The court also rejected

plaintiffs' argument that the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b), preempts AB 290. 1-PER-35-37.

Anti-steering provisions: The district court concluded that AB 290's requirement that financially interested entities not "steer, direct, or advise" patients in their choice of health insurance coverage, §§ 2(a), 3(b)(4), 5(b)(4), violated the First Amendment. Applying the Supreme Court's commercial speech framework, *see Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n of N.Y.*, 447 U.S. 557, 566 (1980), the court held that while "the record supports the State's position that a significant economic incentive exists to steer dialysis patients into private insurance," the State had "not met its burden of showing patient harm" attributable to steering, 1-PER-42, and the anti-steering provision was "more extensive than necessary" to protect the State's interests, 1-PER-45.

Prohibition on conditioning financial assistance: Sections 3(b)(2) and 5(b)(2) of AB 290 specify that entities like AKF may not "condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device." The district court held that these provisions "constitute[] unjustified government interference with AKF's choice to enter into and maintain relationships with certain patients based on its organizational mission," violating AKF's First Amendment right of association. 1-PER-53.

Other claims: The district court rejected plaintiffs' claims that AB 290 violated their First Amendment right to petition, 1-PER-56-57; the Contracts Clause, 1-PER-58-60; the Due Process Clause, 1-PER-60-61; and the Takings Clause, 1-PER-61-63.

Severability: Applying California law severability principles, the court concluded that the provisions of AB 290 it had determined to be unlawful were "grammatically, functionally, and volitionally separable" from the remainder of the statute. 1-PER-63-66. The court thus entered a permanent injunction barring enforcement of Sections 2(a), 3(b)(4), and 5(b)(4) (the anti-steering provisions); Sections 3(b)(2) and 5(b)(2) (the prohibition on conditioning financial assistance); and Sections 3(c)(2) and 5(c)(2) (the disclosure-to-insurers requirement). 1-PER-5-6, 67-68. The remainder of the statute is valid and enforceable, though pursuant to a stipulation reached by the parties, the district court's preliminary injunction remains in effect pending the resolution of this appeal. 1-PER-6-7.

SUMMARY OF ARGUMENT

I. The district court correctly rejected plaintiffs' First Amendment and preemption challenges to several of AB 290's provisions.

A. AB 290's reimbursement cap does not violate dialysis providers' or AKF's First Amendment rights. It is an economic regulation of non-expressive conduct, limiting a provider's reimbursement rates for patients whose health

insurance premiums the provider subsidizes through contributions to AKF. While charitable contributions may often qualify as expressive for First Amendment purposes, a reasonable observer here would not view dialysis providers' contributions to AKF or similar entities as expressive in nature. Rather, they are a self-interested financial arrangement designed to increase providers' overall revenue by facilitating a shift of patients into commercial insurance plans. *Cf. Edge v. City of Everett*, 929 F.3d 657, 669 (9th Cir. 2019).

Even if the Court were to conclude that the reimbursement cap burdens providers' First Amendment rights, the cap is a permissible regulation of expressive conduct under *United States v. O'Brien*, 391 U.S. 367 (1968). It furthers the State's substantial interest in preventing the unjust enrichment of dialysis providers and in protecting patients and the stability of the health insurance market. Absent the cap, an influx of ESRD patients—who have very high healthcare costs—into commercial insurance plans would likely lead to an increase in premiums. The reimbursement cap is also appropriately tailored to that interest: it targets the specific conduct causing the harms the State seeks to combat, restricts no more expression than necessary, and leaves open alternative channels for dialysis providers to express their support for entities such as AKF.

Plaintiffs' arguments to the contrary are unpersuasive. No form of heightened scrutiny (apart from possibly the *O'Brien* framework) applies to AB 290, but in

any event, the reimbursement cap would survive any mode of analysis other than strict scrutiny. The reimbursement cap is not unconstitutionally overbroad; plaintiffs have not shown that a substantial number of its applications would violate the First Amendment. And the cap is severable from the provisions the district court invalidated, including the requirement that entities like AKF disclose to health insurers the names of patients receiving third-party premium support.

B. AB 290's requirement that entities like AKF inform patients of all available health coverage options does not violate the First Amendment. It is a modest, noncontroversial disclosure in the commercial context that is permissible under *Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985).

C. Federal law does not preempt AB 290. AB 290 does not conflict with the Beneficiary Inducement Statute, 42 U.S.C. § 1320a-7a, because there is no substantial likelihood that patients receiving third-party premium support will become aware that their dialysis providers made contributions to AKF. And even if some patients did, that would only occur long after they had selected a provider free from any undue influence, which is the core concern of the statute and HHS's Advisory Opinion 97-1. Nor does AB 290 interfere with the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b), which generally prohibits commercial health insurance plans from discriminating against patients who are also covered by Medicare.

II. The district court erred in concluding that two sets of AB 290's provisions—prohibiting the conditioning of financial assistance and requiring the disclosure of patient names to insurers—violate the First Amendment.[4]

A. AB 290 permissibly prohibits entities like AKF from conditioning premium support to ESRD patients on the patient's course of treatment. This is a typical consumer-protection regulation that ensures financially interested entities will not unduly influence a patient's decision regarding what treatment option to pursue. It does not impair AKF's ability to select its members or officers, or to define its organizational mission.

B. The requirement that entities like AKF disclose to insurers the names of patients receiving premium assistance is valid under the *Zauderer* framework. It involves a disclosure of purely factual and uncontroversial information—patient names—and furthers the important state interest of allowing health insurers to confirm that dialysis providers are adhering to AB 290's reimbursement cap.

STANDARD OF REVIEW

This Court "review[s] a district court's order granting summary judgment de novo[,] . . . viewing the evidence and drawing all inferences in the light most

[4] The State does not contest on appeal the district court's conclusion that AB 290's anti-steering provisions violate the First Amendment. *See infra* at 58-59.

favorable to the non-moving party." *Scanlon v. County of Los Angeles*, 92 F.4th 781, 796 (9th Cir. 2024).

ARGUMENT

The district court rightly rejected most of plaintiffs' challenges to AB 290. Its judgment should be affirmed, except for two discrete provisions of AB 290—the prohibition on conditioning financial assistance and a disclosure requirement—that the court wrongly invalidated under the First Amendment.

I. THE DISTRICT COURT CORRECTLY REJECTED PLAINTIFFS' CHALLENGE TO AB 290'S REIMBURSEMENT CAP AND RELATED PROVISIONS

A central objective of AB 290 is to prevent dialysis providers from unjustifiably increasing the reimbursement rates they receive by facilitating a shift of patients from Medicare or Medicaid to commercial insurance plans. To achieve that goal, the Legislature limited the reimbursement rates providers may receive for patients whose insurance premiums are subsidized by entities like AKF that receive financial support from dialysis providers. And to ensure that those patients can make an educated choice regarding health insurance coverage, the Legislature required financially interested entities to inform them of all available health insurance coverage options. The district court correctly recognized that these provisions do not violate the First Amendment, and it also properly rejected Plaintiffs' federal preemption and Petition Clause claims.

A. The Reimbursement Cap Does Not Violate the First Amendment

AB 290's reimbursement cap provisions specify that if a "financially interested provider" (such as DaVita or Fresenius) "makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment" (such as AKF), "the amount of reimbursement . . . that shall be paid" to the provider is governed by the statute. AB 290 §§ 3(e)(1), 5(e)(1). The reimbursement rate "shall be the higher of the Medicare reimbursement" rate or "the rate determined pursuant to" an "independent dispute resolution process" to be established by the Department of Managed Health Care or the Department of Insurance. *Id.* §§ 3(e)(1), 3(f)(1), 5(e)(1), 5(f)(1); *see supra* at 10-11 n.3.

The district court correctly rejected plaintiffs' First Amendment challenge to these provisions. Because the reimbursement cap constitutes economic regulation of conduct without any meaningful expressive component, no further First Amendment scrutiny is required. And even if it were deemed to be a regulation of expressive conduct, it passes constitutional muster because it advances the State's strong interest in regulating health insurance markets and is appropriately tailored to that objective. *See O'Brien*, 391 U.S. at 377.[5]

[5] The district court appears to have conflated the question of whether the reimbursement cap regulates expressive conduct—and thus implicates the First Amendment at all—with the separate question of whether, assuming it does so, it (continued…)

1. The reimbursement cap is an economic regulation of non-expressive conduct

As the Supreme Court has repeatedly emphasized, "the First Amendment does not prevent restrictions directed at commerce or conduct from imposing incidental burdens on speech" or association. *Sorrell v. IMS Health, Inc.*, 564 U.S. 552, 567 (2011). Rather, "First Amendment protection" extends "only to conduct that is inherently expressive." *Rumsfeld v. Forum for Acad. & Inst. Rights, Inc.* (*FAIR*), 547 U.S. 47, 66 (2006). The task for courts is to "distinguish impermissible content-based speech restrictions from traditional or ordinary economic regulation of commercial activity that imposes incidental burdens on speech" or association. *Barr v. Am. Ass'n of Pol. Consultants, Inc.*, 591 U.S. 610, 620 (2020) (plurality opinion).

In *Interpipe Contracting, Inc. v. Becerra*, 898 F.3d 879 (9th Cir. 2018), this Court synthesized the Supreme Court's decisions in this area and identified three situations in which "[c]onduct-based laws may implicate" the First Amendment. *Id.* at 895. They may do so "where (1) the conduct itself communicates a message" (*i.e.*, amounts to pure speech), "(2) the conduct has an expressive

---

nonetheless satisfies the relevant level of First Amendment scrutiny. *See* 1-PER-49-50. The court "agree[d]" that the reimbursement cap is "a regulation on economic activity or nonexpressive conduct," but then went on to apply what it described as "intermediate scrutiny" under which "the State must show that the Reimbursement Cap directly advances a substantial state interest." *Id.*

element," or "(3) even though the conduct standing alone does not express an idea, it bears a tight nexus to a protected First Amendment activity." *Id.* (citations omitted). As in *Interpipe*, AB 290's reimbursement cap does not fall into any of these categories. *See id.* at 895-96; 1-PER-48-51.[6]

First, the conduct at issue plainly is not itself speech. The reimbursement cap applies where a financially interested provider "makes a third-party premium payment or has a financial relationship with the entity making the third-party premium payment." AB 290 §§ 3(e)(1), 5(e)(1). Making a third-party premium payment or having a financial relationship with an entity that does is a business activity; it does not itself "communicate[] a message." *Interpipe*, 898 F.3d at 895. Just as an employer's payment of wages is an economic activity rather than speech, *see id.*, and just as educational institutions are "not speaking when they host interviews and recruiting receptions," *FAIR*, 547 U.S. at 64, dialysis providers' financial contributions to AKF "lack the expressive quality" of media such as "a

[6] Plaintiffs seek to distinguish *Interpipe* on the ground that it involved "'payment of wages,' not charitable contributions." Fresenius Br. 34. That argument is misplaced. Even if this case is not factually identical to *Interpipe*, that decision still provides the Ninth Circuit's governing framework for determining whether a conduct-based law like AB 290 implicates the First Amendment. Moreover, while this case does not involve payment of wages, it is analogous to *Interpipe* in that the plaintiff challenges a law that regulates its business conduct in a way that, in its view, interferes with its ability to express its preferred message. *See* 898 F.3d at 883-84. That theory failed in *Interpipe*, *id.* at 895-96, and lacks merit here as well.

parade, a newsletter, or the editorial page of a newspaper," *id.*, and thus do not inherently communicate any message.

Second, under the circumstances of this case, providers' contributions to AKF do not constitute conduct with an "expressive element" sufficient to implicate the First Amendment. *Interpipe*, 898 F.3d at 895. "In deciding whether particular conduct possesses sufficient communicative elements to bring the First Amendment into play," courts assess "whether 'an intent to convey a particularized message was present, and whether the likelihood was great that the message would be understood by those who viewed it.'" *Texas v. Johnson*, 491 U.S. 397, 404 (1989) (alteration omitted). As this Court has explained in applying this two-part test, "[c]ontext is everything when deciding when others will likely understand an intended message conveyed through expressive conduct," requiring a careful analysis of "the surrounding circumstances" of the case. *Edge*, 929 F.3d at 669.

The district court correctly determined that the reimbursement cap is "a restriction on economic activity or nonexpressive conduct." 1-PER-49. A reasonable observer would likely perceive providers' contributions to AKF as a "quid pro quo arrangement that secures a later return on investment in the form of higher private insurance reimbursements," not an "expressive avenue by which providers join and support AKF's mission." *Id.* (internal quotation marks and alteration omitted). The evidence showed an "elaborate financial relationship

between AKF and dialysis providers" under which providers make "substantial donations to AKF, calibrated to cover the amounts in premiums provider patients would require for commercial insurance premiums." 1-PER-49; *see* 1-SER-65, 169, 175. Providers and AKF "operate under an understanding that AKF will route . . . much of the 'donations' back to the providers' patients in amounts calculated to cover their premiums." 1-PER-49; *see* 1-SER-66, 214. Indeed, AKF explicitly urged providers to make "fair share" contributions in proportion to the number of patients they referred to AKF for premium assistance. 1-SER-175, 182. "By funneling money through AKF" in this way, the providers seek to "reap the reimbursement rates for commercial coverage, which are considerably higher than for public coverage." 1-PER-49. The financial benefit to providers from those higher reimbursement rates—on the order of $100,000 more per patient per year—is "much larger" than the "relatively small outlay" required to "pay an individual's premium to enroll in commercial coverage." 1-PER-50; *see* 1-SER-54-55, 122.

Under those circumstances, providers' contributions to AKF are not meaningfully expressive in nature. Even assuming plaintiffs have a subjective intent to express support for AKF's mission through their contributions, there is no significant "likelihood," let alone a "great" likelihood, that a reasonable observer would perceive providers' contributions to AKF as expressive. *Johnson*, 491 U.S. at 404. Rather, like the district court, a reasonable observer would likely perceive

the contributions to be part of a self-interested financial scheme to increase providers' own reimbursement rates. In *Edge*, for example, this Court explained that a municipal ordinance prohibiting baristas from wearing sexually suggestive clothing did not restrict expressive conduct because, in light of "[t]he commercial setting," a reasonable observer would perceive "[t]he baristas' act of wearing pasties and g-strings in close proximity to paying customers" as a strategy for soliciting tips from those customers, not as conveying a message of female empowerment. 929 F.3d at 669; *see id.* at 662. And a financially motivated contribution of the kind AB 290 regulates is not remotely comparable to the kinds of conduct that courts have deemed expressive for First Amendment purposes, such as burning an American flag, *see Johnson*, 491 U.S. at 406; or affixing a peace sign to it, *see Spence v. Washington*, 418 U.S. 405, 406 (1974) (per curiam); or burning a draft card, *see O'Brien*, 391 U.S. at 369.

Third, the providers' financial contributions to AKF are not conduct that, while itself non-expressive, "bears a tight nexus to a protected First Amendment activity." *Interpipe*, 898 F.3d at 895. For example, unlike Minnesota's tax on certain "ink and paper products used exclusively by news publications," AB 290's reimbursement cap does not "single[] out . . . for special treatment" individuals or entities engaged in publication or expression. *Id.* (citing *Minneapolis Star & Tribune Co. v. Minn. Comm'r of Revenue*, 460 U.S. 575, 578 (1983)). The

reimbursement cap applies to dialysis providers who directly or indirectly subsidize their patients' commercial insurance premiums. *See* §§ 3(e)(1), 5(e)(1). It applies to entities based on their business transactions, not their expression.

Plaintiffs' arguments to the contrary are unavailing. They appear to contend that charitable financial contributions *always* constitute expression for First Amendment purposes. Fresenius Br. 29-30. But none of the cases they cite stands for so broad a proposition. To be sure, in many circumstances, charitable financial contributions will qualify for First Amendment protection—because a reasonable observer will often perceive those contributions to be expressive in nature. But that is not true in every case—and is particularly not true when, as here, the evidence shows that the contributions are merely a "quid pro quo arrangement that secures a later return on investment in the form of higher private insurance reimbursements." 1-PER-49 (internal quotation marks and alteration omitted).

The cases upon which plaintiffs rely (Fresenius Br. 28-30) are readily distinguishable. Both *Roberts v. United States Jaycees*, 468 U.S. 609, 612 (1984), and *Boy Scouts of America v. Dale*, 530 U.S. 640, 644 (2000), involved disputes regarding *membership* in charitable organizations, not financial contributions. Most of the cases plaintiffs cite involving financial contributions, *see* Fresenius Br. 29, arose from *political* contributions, not charitable ones. Those cases rested on the principle—not relevant or disputed here—that "the First Amendment

safeguards an individual's right to participate in the public debate through political expression and political association," including campaign contributions. *McCutcheon v. FEC*, 572 U.S. 185, 203 (2014). And while plaintiffs may be correct (Fresenius Br. 30-31) that conduct such as "distribution of sanctified vegan and vegetarian food," *Krishna Lunch of S. Cal., Inc. v. Gordon*, 797 F. App'x 311, 313 (9th Cir. 2020), or "holding out [a] hand or a cup to receive a donation," *Loper v. N.Y.C. Police Dep't*, 999 F.2d 699, 704 (2d Cir. 1993), can be expressive for First Amendment purposes, those cases are readily distinguishable on their facts. They do not suggest that plaintiffs' financially self-interested contributions meet that standard here.

The main case plaintiffs cite (Fresenius Br. 29) for the proposition that the First Amendment categorically protects charitable financial contributions—*Kammerling v. Massanari*, 295 F.3d 206, 214 (2d Cir. 2002) (per curiam)—is also quite far afield and actually supports the State's position, not plaintiffs'. It concerned whether a recipient of Social Security disability benefits could disclaim her monthly award of benefits in favor of the Social Security Administration (SSA) to "express opposition to the United States government and replenish the depleting SSA fund." *Id.* at 208. The court noted in dicta that charitable contributions are generally "entitled to protection under the First Amendment," but then went on to hold that "any purely communicative aspect of plaintiff's potential waiver of

benefits" did not warrant relief on the facts of that case. *Id.* at 214-15. The same is true here.

Plaintiffs also contend that "[c]haritable contributions do not lose their First Amendment protection just because they provide a financial benefit" to the contributor. Fresenius Br. 31; *see id.* at 31-38. That is true as far as it goes—many charitable contributions are properly viewed as expressive even though they may provide some financial benefit (often in the form of a tax deduction) to the contributor. But the salience and magnitude of a financial benefit are certainly relevant to whether a reasonable observer would perceive the contributions as expressive. In *Edge*, for example, "[t]he commercial setting" and the baristas' "close proximity to . . . customers" who were being solicited for tips led the Court to conclude that the baristas' act of wearing sexually suggestive clothing was non-expressive in the factual context of the case, even if the same act might be expressive in other contexts. 929 F.3d at 669. And where, as here, charitable contributions result in not just some modest financial benefit, but a benefit *well in excess of the contribution amount*, a reasonable observer would surely perceive its "transactional nature," with the contributor "making a relatively small outlay" in order to secure "a much larger payment" in return. 1-PER-50. Because a financial transaction of that kind is not meaningfully expressive, a State may regulate it consistent with the First Amendment.

2. Even if it implicates the First Amendment, the reimbursement cap is constitutional under the *O'Brien* framework for regulation of expressive conduct

For the reasons just discussed, AB 290's reimbursement cap does not restrict plaintiffs' rights of expression or association. But "even on the assumption" that the "communicative element in [plaintiffs'] conduct is sufficient to bring into play the First Amendment, it does not necessarily follow" that the reimbursement cap is unconstitutional. *O'Brien*, 391 U.S. at 376. Under the *O'Brien* framework—which applies to regulations of conduct that impose "incidental limitations on First Amendment freedoms," *id.*—the government may regulate expressive conduct when (1) the regulation "furthers an important or substantial governmental interest," (2) "the governmental interest is unrelated to the suppression of free expression," and (3) the restriction on expression is "no greater than is essential to the furtherance of that interest," *id.* at 377; *see, e.g.*, *Porter v. Martinez*, 68 F.4th 429, 443 (9th Cir. 2023). The reimbursement cap satisfies each of those elements.[7]

[7] Plaintiffs do not argue that AB 290's reimbursement cap is invalid under the *O'Brien* framework. They do contend that the reimbursement cap would fail "intermediate scrutiny" of the kind applied to "pure commercial speech—i.e., 'speech which does no more than propose a commercial transaction.'" Fresenius Br. 42. While the *O'Brien* framework is "a version of intermediate scrutiny," *Recycle for Change v. City of Oakland*, 856 F.3d 666, 669 (9th Cir. 2017), it is distinct in certain respects from a commercial speech analysis. *Infra* at 43-44; *compare O'Brien*, 391 U.S. at 377, *with Cent. Hudson Gas & Elec. Corp. v. Pub. Serv. Comm'n*, 447 U.S. 557, 566 (1980). Regardless, as discussed below, the reimbursement cap survives any form of intermediate scrutiny. *Infra* at 44.

First, the reimbursement cap "furthers an important or substantial governmental interest." *O'Brien*, 391 U.S. at 376. There is no question that states have an important interest in regulating health care and health insurance, which are "areas traditionally left to state regulation." *Operating Engrs. Health & Welfare Trust Fund v. JWJ Contracting Co.*, 135 F.3d 671, 677 (9th Cir. 1998); *accord, e.g.*, *Medtronic, Inc. v. Lohr*, 518 U.S. 470, 475 (1996). In particular, "state regulations governing the reimbursement rates for healthcare providers" are designed to advance the "important state interest" in "'low-cost, high-quality health care.'" *Willamette Family, Inc. v. Allen*, 643 F. Supp. 3d 1180, 1191 (D. Or. 2022) (quoting *Delta Dental Plan of Cal., Inc. v. Mendoza*, 139 F.3d 1289, 1295 (9th Cir. 1998)).

As the district court recognized, the reimbursement cap furthers this governmental "interest in regulating . . . health and insurance markets" by "eliminating preferentially high reimbursement rates for privately insured dialysis patients" who would otherwise be covered by public insurance programs that pay lower reimbursement rates. 1-PER-50-51. In enacting AB 290, the Legislature found that these elevated reimbursement rates "result in an unjust enrichment of the financially interested provider at the expense of consumers purchasing health insurance." *Id.* § 1(c). And "[e]ncouraging patients to enroll in commercial insurance coverage for the financial benefit of the provider . . . can also expose

patients to direct harm." *Id.* The reimbursement cap prevents these adverse effects in a straightforward way—by limiting providers' reimbursement rates for patients receiving third-party premium assistance to either the Medicare rate or a rate determined by an independent dispute resolution process. As the district court reasoned, the reimbursement cap "directly advances the State's interest in neutralizing the reimbursement rates for commercial insurance" as compared to public insurance plans. 1-PER-51.

Ample evidence in the record supports that conclusion. The third-party premium support AKF provides has facilitated a substantial shift of ESRD patients into commercial insurance plans. *See* 1-SER-255, 269-274; 2-SER-303. The evidence supports the Legislature's finding that shifting these patients—who typically have far higher healthcare costs than non-ESRD patients—into the commercial insurance market causes all enrollees to "pay higher health insurance premiums due to the distortion of the insurance risk pool." AB 290, § 1(e). For instance, the State's expert, John Bertko, found that individual-market plans in California would likely experience a premium increase because of the distortion of the risk pool caused by an influx of ESRD patients. 1-SER-243. While the exact magnitude of that premium increase would depend on the number of ESRD patients enrolling in commercial insurance plans, Mr. Bertko found that an

"increase of approximately 1.7%" would be expected to occur for each additional thousand ESRD patients enrolling in individual-market plans. 1-SER-244.

Other studies have arrived at similar conclusions. For instance, an analysis led by Dr. Erin Trish, upon which Mr. Bertko relied in part, found that average monthly healthcare spending for ESRD patients was *33 times higher* than for non-ESRD patients, and that shifting 10% of Medicare enrollees with ESRD into the individual insurance market would "increase . . . overall average spending by 4.1%." 1-SER-255. A J.P. Morgan analysis likewise concluded that shifting ESRD patients from Medicare to commercial insurance would lead to "nearly $1.7 billion" in total additional healthcare costs each year. 1-SER-150. Given all this evidence, the district court rightly credited the Legislature's conclusion that elevated reimbursement rates "unjustly drive up the cost of care" for patients enrolled in commercial plans. 1-PER-51; *see* AB 290, § 1(*i*).

Plaintiffs disagree, but their arguments are unpersuasive. Tellingly, plaintiffs introduced no expert testimony of their own or other evidence to refute the commonsense conclusion that the "hundreds of millions of dollars" they receive in elevated reimbursement rates through third-party premium support, 1-PER-51, ultimately translates into increased healthcare costs for patients in commercial insurance plans. Plaintiffs could not muster such evidence for a simple reason: it does not exist. Indeed, an analysis commissioned by AKF found that due to the

enrollment of ESRD patients in commercial insurance plans, in each year between 2015 and 2018, premiums for those plans were higher than they would otherwise have been. 2-SER-303.

Rather than introduce their own evidence, plaintiffs seek to discredit Mr. Bertko's analysis, but they fail to do so. They assert that he supposedly admitted that his projected premium increases were "based on misstatements, mistakes, [and] guesses." Fresenius Br. 49 (internal quotation marks and alterations omitted). That is not a fair or accurate characterization of his deposition testimony.[8] While it may be possible for reasonable people to disagree with some of Mr. Bertko's particular figures and estimates, the analysis commissioned by AKF likewise concluded that the enrollment of ESRD patients had led to an increase in commercial insurance premiums in California. 2-SER-303. And plaintiffs point to nothing that would disturb his bottom-line, intuitive finding that an influx of ESRD patients with very high healthcare costs into commercial insurance plans would adversely affect the "risk mix" of the private insurance

[8] For example, Mr. Bertko acknowledged that it was a "misstatement" to say that 3,000 additional ESRD patients had enrolled in Covered California health in 2016 alone. 1-SER-283; *see* 1-SER-276-280. He clarified that the data indicated that approximately 700 new ESRD patients had enrolled during that year, 1-SER-279, and that between 3,000 and 6,000 were likely to do so in the coming years, 1-SER-269-274—hardly an unreasonable estimate given that 700 joined in a single year.

patient pool, which would ultimately translate into an increase in premiums. 1-SER-285.[9]

Second, the State's interests are "unrelated to the suppression of free expression." *O'Brien*, 391 U.S. at 377. The State seeks to prevent unjust enrichment, to lower healthcare costs, and to protect patients, not to prevent providers like DaVita and Fresenius from expressing their support for AKF's mission. The State has no objection to that mission or providers' support for it, only to the providers using their contributions to secure inflated reimbursement rates and harm patients. The situation is analogous to *Recycle for Change*, 856 F.3d at 668, where this Court upheld a municipal ordinance that restricted charitable solicitations at unstaffed drop boxes. The Court explained that even if the ordinance restricted expression, it did so to combat problems associated with unstaffed drop boxes like "blight, illegal dumping, and graffiti," not the expression itself. *Id.* at 674-75.

[9] Plaintiffs also fault Mr. Bertko for not "isolat[ing] the effect of ESRD patients who were supposedly steered by dialysis providers or entities like AKF." Fresenius Br. 49. That misunderstands the State's interest, which is not limited to patients who are "steered" in the sense of being encouraged or urged by AKF or providers to enroll in commercial insurance plans. Rather, the point is that third-party premium support has resulted in thousands of ESRD patients joining commercial insurance plans, the vast majority of whom could not remain on such plans absent those subsidies. *See* 1-PER-18-19. That drives up costs for other enrollees regardless of whether those patients are "steered" or not.

Third, any restriction on expression imposed by the reimbursement cap is "no greater than is essential to the furtherance" of the government's interest. *O'Brien*, 391 U.S. at 376. To satisfy this element of the test, "a regulation 'need not be the least restrictive or least intrusive means' of serving that interest." *Porter*, 68 F.4th at 443 (quoting *Ward v. Rock Against Racism*, 491 U.S. 781, 798 (1989)). It is sufficient for the government to show that its interest "would be achieved less effectively absent the regulation" and that the regulation does not "burden substantially more speech than is necessary" to advance the government's interests. *Ward*, 491 U.S. at 799.

The reimbursement cap meets that standard. By limiting the reimbursement rates dialysis providers receive for patients receiving third-party premium support, the cap directly achieves the State's interest in preventing the unjust enrichment of providers and the distortion of California's private health insurance market. And as the district court recognized, it "does so without restricting the dialogue between patients and providers." 1-PER-51. Unlike the anti-steering provisions—which the district court enjoined, a result the State does not contest on appeal, *see infra* at 58-59—the cap allows providers to advise patients regarding insurance options as they see fit. They merely cannot obtain elevated reimbursement rates by subsidizing their patients' insurance premiums through AKF.

AB 290 also "leave[s] open ample alternative channels," *Porter*, 68 F.4th at 443, for providers to publicly express their support for AKF and similar entities. They may do so, for example, through corporate statements, advertising campaigns, and other avenues apart from making financial contributions. *Cf. Recycle for Change*, 856 F.3d at 675 (noting that charities could continue to "solicit charitable donations in ways other than operating an unattended collection box"). Of course, providers remain free to contribute to AKF and subsidize their patients' insurance premiums; they just cannot enrich themselves through elevated reimbursement rates while doing so. To the extent providers may choose to discontinue their contributions to AKF because of the reimbursement cap, that would further confirm that their contributions to AKF are not really an "expressive avenue by which providers join and support AKF's mission, but a quid pro quo arrangement that secures a later return on investment." 1-PER-49 (internal quotation marks and alterations omitted); *see supra* at 26-28.

Plaintiffs' arguments that the reimbursement cap is "not appropriately tailored" to the State's interests, Fresenius Br. 53; *see id.* at 53-56, miss the mark and largely reflect a misunderstanding of the State's interests. For instance, plaintiffs suggest that "[t]he state could bar enrollment in insurance plans that it views as less desirable." *Id.* at 53. But the State does not view any kind of insurance plan as more desirable or less desirable; its objection is to providers

exploiting the system and distorting insurance markets by subsidizing their patients' insurance premiums (through AKF) to obtain higher reimbursement rates. Barring enrollment in plans—besides being a far *more* "drastic" approach than the reimbursement cap, *id.*—would be a poor fit for that objective. Similarly, while the State "could bar providers from making false or misleading statements about insurance options," *id.* at 53-54, there is no reason to think that the problems of unjust enrichment and market distortion stem primarily from false or misleading statements made to patients.

Plaintiffs also posit that "the State could have directly regulated insurance premiums or reimbursement rates." Fresenius Br. 54. But the reimbursement cap *is* properly viewed as a form of targeted rate regulation, as plaintiffs themselves recognize: it "targets . . . a subset" of providers' rates. *Id.* at 55. Plaintiffs complain that this approach is "underinclusive[]," because it does not regulate reimbursement rates paid for patients not receiving third-party premium support. *Id.* That argument also misapprehends the State's interest. AB 290 does not seek to alter the fact—a foundational reality of our healthcare system—that commercial insurance plans generally pay higher reimbursement rates than Medicare or Medi-Cal. 1-SER-54-55, 122. Its goal is specifically to stop providers from "artificially increasing the number of their patients who have commercial insurance coverage," 1-PER-51, which unfairly pads their bottom line at the expense of other enrollees

in private insurance plans, who pay higher premiums as a result. The reimbursement cap is carefully tailored to achieve that goal without disturbing the broader healthcare and health insurance system.

3. Plaintiffs' arguments for applying heightened scrutiny are unpersuasive, but the reimbursement cap would survive any mode of analysis other than strict scrutiny

In place of the *O'Brien* framework for government regulations of expressive conduct, plaintiffs propose three different forms of heightened scrutiny they believe should apply instead—strict scrutiny, exacting scrutiny, and the form of intermediate scrutiny that applies to regulations of commercial speech. Those modes of analysis are inapposite. But even if exacting scrutiny or intermediate scrutiny were applied, the reimbursement cap should nonetheless be upheld.

Plaintiffs briefly and halfheartedly argue that because the reimbursement cap ostensibly "imposes burdens on particular speakers in order to discourage particular contributions to particular recipients," it "is subject to strict scrutiny." Fresenius Br. 39. That is not an accurate characterization of the reimbursement cap, which applies to *any* dialysis provider that makes third-party premium payments or has a financial relationship with an entity that does so. *See* AB 290 §§ 3(e)(1), 5(e)(1). Plaintiffs assert that AB 290 supposedly "single[s] out 'the two largest dialysis companies' in the United States," Fresenius Br. 41, but that is only true in the sense that the Legislature noted that those two companies (*i.e.*, DaVita

and Fresenius) "control 77 percent of California's dialysis clinics" and "account for 92 percent of all dialysis industry revenue" nationwide, AB 290, § 1(g). Plaintiffs cannot credibly complain that a generally applicable law regulating a highly concentrated industry impermissibly targets the two companies with by far the largest market shares in the industry. The cases plaintiffs cite, *see* Fresenius Br. 41-42, are not remotely analogous.[10]

Plaintiffs next argue that AB 290 should be subject to "exacting scrutiny," which they contend "applies to laws that restrict or burden charitable or political contributions." Fresenius Br. 39. Yet they fail to cite any case applying exacting scrutiny to a law regulating charitable contributions—much less financially self-interested charitable contributions of the kind AB 290 targets. While it is true that exacting scrutiny often "applies to political contribution limits" and to certain "disclosure requirements," Fresenius Br. 39 (citing *McCutcheon*, 572 U.S. at 199, and *Americans for Prosperity Found. v. Bonta*, 594 U.S. 595, 607 (2021)), AB 290's reimbursement cap does not involve either.

[10] *See Minneapolis Star*, 460 U.S. at 581 (Minnesota law impermissibly "created a special tax that applies only to certain publications protected by the First Amendment"); *Time Warner Cable, Inc. v. Hudson*, 667 F.3d 630, 639 (5th Cir. 2012) (Texas law "plainly discriminates against a small and identifiable number of cable providers," treating them worse than other cable providers).

Plaintiffs acknowledge as much, but argue that "[t]he same logic" that led courts to apply exacting scrutiny in those cases "applies to charitable contributions." Fresenius Br. 40. That would be true only for charitable contributions that are primarily expressive in nature. For contributions that are either non-expressive or where the donor's expression is incidentally burdened pursuant to a valid regulation of economic conduct, the basis for applying exacting scrutiny—namely, "limitations on core First Amendment rights of political expression," *McCutcheon*, 572 U.S. at 197—is absent. Moreover, unlike in other exacting scrutiny cases, there is no allegation here that the State is seeking to create any "chilling effect," *Americans for Prosperity*, 594 U.S. at 606, that would thwart the mission of a controversial advocacy group, *see, e.g.*, *NAACP v. Alabama ex rel. Patterson*, 357 U.S. 449, 462 (1958). The State has no objection to the mission of AKF or similar entities—only to providers using those entities to facilitate a "quid pro quo arrangement that secures a later return on investment in the form of higher private insurance reimbursements." 1-PER-49.

As an additional fallback position, plaintiffs suggest that "intermediate scrutiny" of the sort that applies to "pure commercial speech" should apply. Fresenius Br. 42; *see Cent. Hudson*, 447 U.S. at 566. Intermediate scrutiny under *Central Hudson* is somewhat similar to the *O'Brien* framework, and would therefore be a more appropriate mode of analysis than either strict scrutiny or

exacting scrutiny. *See supra* at 32 n.7. But the *Central Hudson* test applies to "content-based restrictions on commercial speech," *Pac. Coast Horseshoeing Sch., Inc. v. Kirchmeyer*, 961 F.3d 1062, 1068 (9th Cir. 2020)—that is, regulations that target speech itself, not conduct. Where a law "regulates conduct but incidentally burdens expression," whether that expression is commercial or noncommercial, the *O'Brien* framework is more appropriate. *Id.*

In any event, AB 290's reimbursement cap survives either exacting scrutiny or *Central Hudson* intermediate scrutiny. Exacting scrutiny requires the government to show "a substantial relation between the disclosure requirement and a sufficiently important governmental interest," and that the regulation is "narrowly tailored to the government's asserted interest"—though unlike strict scrutiny, "exacting scrutiny does not require that disclosure regimes be the least restrictive means of achieving their ends." *Americans for Prosperity*, 594 U.S. at 608. *Central Hudson* requires the government to show that its interest is "substantial," that the regulation "directly advances" that interest, and that the regulation "is not more extensive than is necessary to serve that interest." *Retail Digital Network, LLC v. Prieto*, 861 F.3d 839, 844 (9th Cir. 2017). The reimbursement cap satisfies these standards for the reasons discussed above. It furthers a substantial government interest, *see supra* at 33-37, and does so in a direct and appropriately tailored way, *see supra* at 38-41.

4. The reimbursement cap is not unconstitutionally overbroad

Plaintiffs separately argue that the reimbursement cap violates the First Amendment on an overbreadth theory. Fresenius Br. 56-61. If the Court agrees that providers' contributions to AKF are not expressive in nature, *supra* at 24-31, then plaintiffs' overbreadth theory fails because none of AB 290's applications are unconstitutional. And even if plaintiffs were correct that the reimbursement cap should be evaluated as a regulation of commercial speech, *supra* at 43-44, their overbreadth theory would still fail because "the overbreadth doctrine does not apply to commercial speech." *Vill. of Hoffman Estates v. Flipside, Hoffman Estates, Inc.*, 455 U.S. 489, 497 (1982) (citing *Cent. Hudson*, 447 U.S. at 565 n.8).

Regardless, the overbreadth argument lacks merit. A statute is unconstitutionally overbroad if "a substantial number of its applications are unconstitutional, judged in relation to the statute's plainly legitimate sweep." *United States v. Stevens*, 559 U.S. 460, 473 (2010). That standard is not met here. Plaintiffs contend that the reimbursement cap is overbroad because it applies not just to "contributions to AKF in particular" but rather "deters all kinds of healthcare providers from making all kinds of donations to all kinds of premium-assistance charities." Fresenius Br. 57. But that contradicts plaintiffs' own argument that the regulation impermissibly "single[s] out" DaVita, Fresenius, and AKF, *id.* at 41. Plaintiffs cannot have it both ways—the reimbursement cap cannot

both be overbroad and too narrowly focused on certain entities. While the conduct of large dialysis providers and AKF were the most salient examples of the kind of conduct the Legislature sought to restrict, *see* AB 290 §§ 1(g), 1(h), the Legislature properly enacted a statute of general applicability that prohibits *any* healthcare provider from obtaining elevated reimbursement rates by subsidizing their patients' health insurance premiums. While the statute could theoretically apply to "general physicians, psychiatrists, allergists, dentists" and other physicians who donate to AKF, Fresenius Br. 58, plaintiffs cite no actual instance of these providers' contributions being chilled. Absent such evidence, there is no basis for concluding that the overbreadth standard is met.

In addition, while plaintiffs express concern that the reimbursement cap will chill charitable contributions from healthcare providers, Fresenius Br. 59-60, they acknowledge that the statute only applies to charities and other entities that "receive[] the majority of [their] funding from one or more financially interested providers of healthcare services." AB 290, §§ 3(h)(2)(B), 5(h)(1)(B). Most charities—at least, those that do not primarily serve as a vehicle for financially self-interested contributions by healthcare providers—will not meet that condition, so the reimbursement cap will not apply. And if any contributor is "uncertain" whether a particular charity qualifies, Fresenius Br. 59, the contributor can simply

ask the charity. That modest, hypothetical burden on entities other than plaintiffs themselves provides no basis for invalidating the reimbursement cap.

5. The reimbursement cap is severable from the provisions of AB 290 that the district court invalidated

Plaintiffs next argue (Fresenius Br. 61-66; AKF Br. 57-58) that even if the reimbursement cap is valid on its own, it "must be struck down because it is inseverable from" AB 290's provisions requiring financially interested entities to disclose to insurers "the name of [each] enrollee . . . on whose behalf a third-party premium payment" is made. AB 290 §§ 3(c)(2), 5(c)(2). The district court held that these provisions violate the First Amendment. The district court erred in reaching that conclusion, and this Court should reverse on that issue. *Infra* at 62-65. But even if the Court disagrees, the reimbursement cap is severable from these provisions, as the district court properly concluded. 1-PER-66.

Severability of a state statute is a matter of state law, and California courts analyze severability by considering whether the "invalid provision" is "grammatically, functionally, and volitionally separable" from the remainder of the law. *Cal. Redev. Ass'n v. Matosantos*, 53 Cal. 4th 231, 271 (2011). Plaintiffs contend that the reimbursement cap is "neither functionally nor volitionally separable" from the insurer-disclosure provisions. Fresenius Br. 63. A statute is functionally severable if "the remainder of the statute is complete in itself" and can function without the invalid provisions, and is volitionally severable if the

Legislature would still have adopted it had it "foreseen the partial invalidation of the statute." *Matosantos*, 53 Cal. 4th at 271 (internal quotation marks omitted).

The reimbursement cap is severable from the insurer-disclosure provisions because while the absence of those provisions will make it more difficult for insurers to monitor providers' compliance the reimbursement cap, the cap would still function appropriately. Without the insurer-disclosure provisions, insurers may be unable to ascertain which of their enrollees are receiving third-party premium assistance, and thus unable to confirm whether providers' billing conforms to the reimbursement cap as to those patients. But providers will remain under an obligation not to accept reimbursement for those patients in an amount that exceeds the cap. *See* AB 290 §§ 3(e)(1), 5(e)(1) (cap governs "the amount of reimbursement . . . that shall be paid" to providers). And the Attorney General could bring an enforcement action to compel compliance with that obligation and recover penalties, *see, e.g.*, Cal. Bus. & Prof. Code §§ 17200, 17204, 17206, even if insurers themselves may find it difficult monitor providers' compliance. That is a workable regulatory scheme, and "nothing suggests" the Legislature would not have adopted it absent the insurer-disclosure provisions, 1-PER-66.

Plaintiffs' assertion that the State "conceded" the inseverability of the reimbursement cap from the insurer-disclosure provisions, Fresenius Br. 62, takes the State's briefing out of context. In urging the district court to uphold the

disclosure provisions, the State pointed out that those provisions "ensure that the reimbursement cap is enforceable" by "health plans and insurance carriers." 2-PER-96. The State correctly noted that the insurer-disclosure provisions are "vital" for the statute to work precisely as the Legislature intended—*i.e.*, for the insurers to be able to confirm that providers' billing complies with the reimbursement cap. *Id.* The State stands by that argument. *Infra* at 62-65. But as just discussed, even without the disclosure provisions, providers would remain under an obligation to abide by the reimbursement cap, and the Attorney General could enforce that obligation.

AKF appears to argue that AB 290's other provisions are also inseverable, AKF Br. 57, but it offers no explanation for its position apart from an unsupported statement that "AB 290 is unworkable without them." AKF Br. 57. That is not sufficient to preserve this broader inseverability argument, *see United States v. Murguia-Rodriguez*, 815 F.3d 566, 573 (9th Cir. 2016), and in any event, it lacks merit for the reasons the district court identified, 1-PER-63-66. Further, while the State does not seek to reverse the district court's judgment that AB 290's anti-steering provisions violate the First Amendment, *infra* at 58-59, the plaintiffs offer no basis for disturbing the district court's conclusion that those provisions are severable from the remainder of AB 290, 1-PER-64-65.

B. The Requirement to Inform Patients of All Available Health Coverage Options Is Permissible Under the *Zauderer* Framework for Commercial Disclosures

The district court also correctly rejected plaintiffs' challenge to sections 3(b)(3) and 5(b)(3) of AB 290, which require financially interested entities making third-party premium payments (such as AKF) to inform patients of "all available health coverage options," including Medicare and Medicaid. 1-PER-54-56. This modest disclosure requirement in the context of a commercial relationship fits comfortably within the *Zauderer* framework. It involves the disclosure of "purely factual and uncontroversial information" that is "'reasonably related' to a substantial government interest" and is not "unjustified or unduly burdensome." *Nat'l Ass'n of Wheat Growers v. Bonta*, 85 F.4th 1263, 1275 (9th Cir. 2023) (quoting *Zauderer*, 471 U.S. at 651).

First, the challenged provisions require the disclosure of nothing more than "purely factual and uncontroversial information." *Zauderer*, 471 U.S. at 651. The information in the disclosure—namely, which health coverage options are available to the patient—is "literally true" and is in no way "inflammatory [or] misleading." *CTIA – The Wireless Ass'n v. City of Berkeley*, 928 F.3d 832, 846-47 (9th Cir. 2019). Nor does it force AKF or similar entities to "take sides in a heated political controversy." *Id.* at 848. It bears virtually no resemblance to the kinds of disclosures that courts have invalidated under the *Zauderer* framework. It does

not, for example, implicate an active scientific debate about whether a product is dangerous or carcinogenic, *see Nat'l Ass'n of Wheat Growers*, 85 F.4th at 1278; nor does it compel discussion of a sensitive or controversial topic like abortion, *see Nat'l Inst. of Family & Life Advocates v. Becerra*, 585 U.S. 755, 768 (2018), or "hate speech, racism, [or] misinformation," *X Corp. v. Bonta*, 116 F.4th 888, 902 (9th Cir. 2024).

Second, the required disclosure is "reasonably related" to a substantial government interest. *Zauderer*, 471 U.S. at 651. Although *Zauderer* itself involved a state's interest in "preventing deception of consumers," *id.*, the framework "applies even in circumstances where the disclosure does not protect against deceptive speech" but instead serves some other "substantial" "governmental interest," *CTIA*, 928 F.3d at 843, 844. "There is no question that protecting the health and safety" of the public "is a substantial government interest." *Id.* at 845. Here, as the district court explained, requiring financially interested entities to inform a patient of their health coverage options advances "the State's interest in increasing consumer transparency, regulating health insurance, and protecting patient choice." 1-PER-56. That interest is particularly acute considering the "powerful incentive" that providers face to encourage patients to enroll in commercial insurance plans rather than Medicare or Medi-Cal. 1-PER-30. The disclosure ensures that patients can make an informed choice

about what health coverage option is in their own best interest, not just the interests of providers or AKF.

Third, the disclosure is not "unjustified or unduly burdensome." *Zauderer*, 471 U.S. at 651. It is a "minimal requirement" that "does not interfere with" financially interested entities' operations or threaten to "drown out" their own messages. *CTIA*, 928 F.3d at 849. The requirement can be satisfied with a short, straightforward summary of the health coverage options that appear to be available to the patient in light of the information known to the financially interested entity—such as "Medicare, Medicaid, individual market plans, and employer plans, if applicable." AB 290 §§ 3(b)(3), 5(b)(3). That contrasts sharply with the cases that have invalidated government regulations under this prong of the *Zauderer* test—such as *American Beverage Ass'n v. City & County of San Francisco*, 916 F.3d 749 (9th Cir. 2019) (en banc), which involved an ordinance requiring advertisements for sugar-sweetened beverages to have a prominent, standardized health warning occupying at least 20% of the advertisement. *Id.* at 753, 756-57. No remotely comparable burden is present here.

In response, AKF contends that the *Zauderer* framework does not apply because the required disclosure "is inevitably intertwined with charitable expressive activities," and because AKF does not itself "provide health insurance coverage." AKF Br. 51. That argument overlooks the reality that a central goal of

AKF's mission is to subsidize health insurance premiums to facilitate the transfer of ESRD patients from Medicare or Medi-Cal to commercial insurance plans. In that context, the relevant "service" AKF provides, *CTIA*, 928 F.3d at 845, is a subsidy to facilitate a change in healthcare coverage—which is a quintessentially commercial activity—and the coverage-disclosure requirement is closely related to that service.

C. Federal Law Does Not Preempt AB 290

AKF contends that two federal laws—the Beneficiary Inducement Statute, 42 U.S.C. § 1320a-7a; and the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b)—preempt AB 290. The district court correctly rejected these theories. 1-PER-31-37. To prevail on their conflict preemption claim, plaintiffs must show either that "compliance with both federal and state regulations is a physical impossibility," or that "the challenged state law 'stands as an obstacle to the accomplishment and execution of the full purposes and objectives of Congress.'" *Arizona v. United States*, 567 U.S. 387, 399 (2012). They cannot do so.[11]

[11] Plaintiffs do not invoke the other varieties of preemption—express preemption and field preemption. *See* 1-PER-31; *Murphy v. NCAA*, 584 U.S. 453, 477-79 (2018) (discussing the "three different types of preemption").

1. AB 290 does not conflict with the federal Beneficiary Inducement Statute or the Petition Clause

AKF argues that the federal Beneficiary Inducement Statute, 42 U.S.C. § 1320a-7a, "as interpreted by [the HHS Inspector General] in Advisory Opinion 97-1," preempts AB 290. AKF Br. 59. The statute prohibits any "offer[]" or "transfer[]" of "remuneration to any individual eligible for benefits" under a federal or state healthcare program that the offeror "knows or should know is likely to influence" the recipient's choice of a healthcare provider. 42 U.S.C. § 1320a-7a(a)(5). AKF's theory is that when patients receiving third-party premium support "receive their explanations of benefits" showing that their insurers paid dialysis providers at the capped rate rather than the ordinary commercial insurance rate, "they will know their dialysis provider donates to AKF." AKF Br. 60. In their view, that would contravene the Beneficiary Inducement Statute as interpreted by Advisory Opinion 97-1, which reasoned that providers' donations to AKF do not constitute unlawful "remuneration" because "the interposition of AKF . . . provides sufficient insulation so that the premium payments should not be attributed to" the dialysis providers. 4-PER-777; *see* AKF Br. 60-62.

As the district court reasoned, this theory fails because there is "no evidence" to support AKF's theory "that patients will connect a lower reimbursement rate appearing on their billing statements with donations to AKF made by their provider." 1-PER-34. And "even if this speculative chain of events were to come

to fruition," the patient "would already have chosen a healthcare provider without undue influence" because they would learn of their provider's donations to AKF only after "picking a provider," "obtaining dialysis," and subsequently "receiving a benefits statement." *Id.* Thus, under the rationale of Advisory Opinion 97-1, "AKF's payments of premiums" with funds contributed by providers subject to the reimbursement cap "is not likely to influence a beneficiary's selection of a particular provider," 4-PER-778, and there is no conflict between state law and the federal statute, *see* 42 U.S.C. § 1320a-7a(a)(5).

AKF offers no persuasive response to this reasoning. In its view, "a patient *could* make the connection" between a "low reimbursement rate" and their providers' contributions, which is "all that is necessary to undermine the safe harbor of Advisory Opinion 97-1." AKF Br. 62. But there remains no actual evidence to support the highly implausible assumption that any substantial number of patients will review their benefits statements, realize that the reimbursement rate is lower than the ordinary rate for commercial insurance patients, and connect that lower rate to their providers' contributions to AKF. Even if all of that did happen, AKF fails to explain how that could conceivably affect the patient's choice of provider, which is the central focus of the statute, *see* 4-PER-777-78; 42 U.S.C. § 1320a-7a(a)(5).

AKF further contends that Section 7 of AB 290—which would have delayed the effective date of the statute for any party who requested an updated advisory opinion from HHS, *see* AB 290, § 7—supposedly "underscores the State's awareness" that AB 290 conflicts with Advisory Opinion 97-1. AKF Br. 62. That is incorrect. The Legislature added Section 7 in response to concerns that AB 290 would remove providers from the safe harbor of Advisory Opinion 97-1; Section 7 alleviates this concern by allowing (but not requiring) providers to test their conflict preemption theory by requesting an updated advisory opinion before the effective date of AB 290. *Supra* at 12-13. The Legislature was in no way *endorsing* the providers' preemption theory; on the contrary, the California Office of Legislative Counsel advised the Legislature that based on the reasoning of Advisory Opinion 97-1, AKF could comply with AB 290 without violating federal law. 1-SER-93, 104-112.

Had any entity sought an advisory opinion and had HHS found that AB 290 would violate federal law as applied to it, the law would not have gone into effect as to that entity. AB 290, § 7. But no party sought an updated advisory opinion, so Section 7 ultimately had no effect. It provides no basis for AKF's preemption theory. Nor does it support AKF's cursory Petition Clause argument. AKF Br. 63-64. Section 7 of AB 290 plainly does not *compel* AKF or anyone else to petition

the government or request an advisory opinion. It *allowed* them to do so before the law would take effect, but they chose not to avail themselves of that option.

2. AB 290 does not conflict with the Medicare Secondary Payer Act

AKF next asserts that AB 290 "conflicts with the policies and goals" of the Medicare Secondary Payer Act, 42 U.S.C. § 1395y(b). AKF Br. 64. Yet AKF fails to cite any provision of that statute that they believe AB 290 interferes with. The Act specifies that "group health plan[s]" may not "take into account" an individual's Medicare coverage, and must offer the "same benefits" to "individual[s] age 65 or older" as they do to younger workers. 42 U.S.C. § 1395y(b)(1)(A)(i). Congress enacted these provisions to end a widespread and costly practice in which insurers would "decline to pay the expense[s]" of patients with both commercial insurance and Medicare "until Medicare had paid first." *DaVita Inc. v. Virginia Mason Mem. Hosp.*, 981 F.3d 679, 685 (9th Cir. 2020).

As the district court reasoned, the Medicare Secondary Payer Act does not preempt AB 290 because nothing in the state statute "requires health plans to differentiate between patients . . . or take into account their Medicare[] eligibility." 1-PER-36. The Medicare Secondary Payer Act imposes certain obligations on commercial health insurers, but AB 290 does not interfere with those obligations in any way. AKF maintains that AB 290 "risks encouraging ESRD patients to leave private insurance coverage prematurely," AKF Br. 65, but fails to explain how it

does so, or in any event why that would conflict with the federal statute. While AB 290's reimbursement cap may well cause some providers to decline to contribute funds used for third-party premium assistance, that does not undermine the policies or objectives of the Medicare Secondary Payer Act. Nothing in the Act reflects a congressional desire to protect the ability of providers to subsidize their patients' insurance premiums to secure elevated reimbursement rates.

II. THE DISTRICT COURT ERRED IN INVALIDATING AB 290'S PROVISIONS PROHIBITING THE CONDITIONING OF FINANCIAL ASSISTANCE AND REQUIRING THE DISCLOSURE OF PATIENT NAMES TO INSURERS

While the district court correctly upheld many of AB 290's provisions, it concluded that others violate the First Amendment. 1-PER-37-46. The district court erred in its analysis of two of these provisions. First, AB 290's directive prohibiting providers and financially interested entities from conditioning financial assistance on a patient's selected course of treatment is a permissible regulation of economic conduct, not a restriction on speech or association. And second, AB 290's requirement that financially interested entities disclose to insurers the names of patients receiving financial assistance—which helps effectuate the statute's reimbursement cap—satisfies the *Zauderer* framework.

The State does not challenge on appeal the district court's conclusion that AB 290's anti-steering provisions—which provide that financially interested entities may not "steer, direct, or advise the patient into or away from" any health

insurance coverage option, §§ 3(b)(4), 5(b)(4)—violate the First Amendment. *See* 1-PER-37-46. As the district court explained, "the record supports the State's position that a significant economic incentive exists to steer dialysis patients into private insurance," 1-PER-42, and there is extensive evidence that steering has occurred, 1-PER-41-42. But given the district court's ruling, the State believes its interest in preventing harmful steering is adequately served by the reimbursement cap, which eliminates the financial incentive for providers to unduly influence a patient's choice of insurance coverage, and "does so without restricting the dialogue between patients and providers," 1-PER-51.

A. AB 290 Permissibly Prohibits Financially Interested Entities from Conditioning Assistance to Patients on the Patient's Selected Course of Treatment

Sections 3(b)(2) and 5(b)(2) of AB 290 specify that financially interested entities may not "condition financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device." The rationale for these provisions is straightforward: they prohibit entities such as AKF that offer premium assistance from discriminating against an ESRD patient who chooses the best course of treatment based on the patient's needs and goals, even if that treatment is not dialysis. The CMS record and other sources confirm that entities like AKF sometimes engaged in the troubling practice of ending premium support for patients who select a non-dialysis treatment option, such as a transplant. 1-SER-

93, 123. The Legislature sought to prohibit that practice, ensuring that patients who are offered premium support may receive it regardless of their choice of treatment option.

The district court determined that these provisions "constitute[] unjustified government interference with AKF's choice to enter into and maintain relationships with certain patients based on its organizational mission," and thus "'interfere with the internal organization or affairs of the group.'" 1-PER-53 (quoting *Jaycees*, 468 U.S. at 622). The court cited *Americans for Prosperity*, 594 U.S. at 606, for the proposition that "[f]reedom of association may be violated where a group is required to take in members it does not want." 1-PER-53.

The district court's analysis was flawed. AB 290 in no way seeks to govern the internal affairs of AKF or similar entities, nor to dictate who they must accept as officers or members. AB 290 instead restricts the external conduct of those entities, prohibiting them from terminating premium support for patients who choose a course of treatment other than dialysis. That is a garden-variety consumer-protection regulation of the kind that is ubiquitous in the context of healthcare and health insurance. *See, e.g.*, *Morris v. Cal. Physicians' Serv.*, 918 F.3d 1011, 1012-13 (9th Cir. 2019); *Hansen v. Group Health Coop.*, 902 F.3d 1051, 1055 (9th Cir. 2018). It seeks to prevent AKF and similar entities from using an offer of premium assistance as a tool for influencing patients to select a

different (and more costly) course of treatment than they might otherwise prefer. It does not implicate AKF's right to select its officers or members or define its charitable mission.

It appears that the district court erred in part by adopting an overly literal interpretation of Sections 3(b)(2) and 5(b)(2). Rejecting the interpretation offered by the California Attorney General, the court appears to have concluded that the prohibition on conditioning financial support on a patient's "eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device" would prohibit financially interested entities from focusing their charitable efforts on ESRD patients as opposed to non-ESRD patients. *See* 1-PER-52-53. To the extent the district court construed the statute in that way, it should not have done so. Nothing in AB 290 prohibits entities like AKF from focusing their efforts on ESRD patients and excluding patients with other types of conditions.

Statutory provisions of California law must be interpreted "in the context of the entire statute and the statutory scheme," *Renee J. v. Superior Court*, 26 Cal. 4th 735, 743 (2001), and "should be construed to avoid all doubts as to [their] constitutionality," *Am. Bank & Trust Co. v. Cmty. Hosp.*, 36 Cal. 3d 359, 376 (1984). Read in context and in light of the constitutional-avoidance canon, Sections 3(b)(2) and 5(b)(2)'s prohibition on "condition[ing] financial assistance on eligibility for, or receipt of, any surgery, transplant, procedure, drug, or device"

prohibits financially interested entities from engaging in the kinds of abusive practices described in the CMS rulemaking record—for instance, withdrawing premium support for ESRD patients based on their chosen course of treatment. 1-SER-10-11, 123-126. These provisions do not prohibit AKF and similar entities from engaging in reasonable, non-abusive practices such as treating ESRD patients differently from non-ESRD patients. At the very least, in the context of this facial First Amendment challenge, the district court erred in rejecting this "narrowing construction" of Sections 3(b)(2) and 5(b)(2) offered by the Attorney General that would preserve their constitutionality. *Virginia v. Am. Booksellers Ass'n*, 484 U.S. 383, 397 (1988); *see Broadrick v. Oklahoma*, 413 U.S. 601, 617-18 (1973) (accepting the "authoritative pronouncement[]" of a "State's Attorney General" regarding "the breadth of a [state] statute").

B. AB 290 Permissibly Requires Financially Interested Entities to Disclose Patient Names to Insurers to Effectuate the Statute's Reimbursement Cap

The district court also invalidated Sections 3(c)(2) and 5(c)(2) of AB 290, which prohibit financially interested entities from making third-party premium payments unless they disclose to the patient's insurer "the name of the enrollee . . . on whose behalf a third-party premium payment . . . will be made." These disclosure provisions are important for effectuating AB 290's reimbursement cap. Without knowing which patients are receiving third-party premium support, health

insurers may find it difficult or impossible to ensure that providers' billing comports with the reimbursement cap. *Supra* at 48-49.

This disclosure requirement is permissible under the *Zauderer* framework because it involves the disclosure of "purely factual and uncontroversial information" in the commercial context that is "'reasonably related' to a substantial government interest" and is not "unjustified or unduly burdensome." *Nat'l Ass'n of Wheat Growers*, 85 F.4th at 1275. The information at issue—the names of enrollees on whose behalf third-party premium payments are made—is "purely factual and uncontroversial," *id.*, and does not relate to any politically sensitive or hot-button topic, *supra* at 50-51. The disclosure requirement is reasonably related to the State's interest in facilitating enforcement of the reimbursement cap—indeed, plaintiffs go so far as to suggest that the reimbursement cap cannot function without it. Fresenius Br. 61-66. While that is overstated, *supra* at 48-49, there is a clear relationship between the two sets of provisions. And the reimbursement cap furthers the State's substantial interest in preventing the unjust enrichment of dialysis providers and protecting California's health insurance market. *Supra* at 33-37.

Accepting plaintiffs' arguments, the district court held that these disclosure provisions unduly "burden AKF's relationship with patients" because they "forc[e] AKF to disclose patient details in a manner it would not agree to" and "expos[e]

information that patients may not want revealed to their insurers." 1-PER-53-54. That is not a sufficient basis for invalidating these provisions under *Zauderer*. Any disclosure requirement could force the regulated entity to disclose information it "would not agree to" otherwise—that is inherent in the nature of mandated commercial disclosures. Plaintiffs have not identified any concrete patient harm that these disclosure provisions would cause. Nor do they point to any concrete harm or burden that AKF would suffer—apart from allowing insurers to confirm providers' compliance with the reimbursement cap, which is the purpose of the disclosure. The district court also concluded, without any explanation, that these disclosure provisions are "not sufficiently tailored," 1-PER-54, but it is difficult to imagine a *more* tailored disclosure requirement. All a financially interested entity must disclose is the name of a patient receiving third-party premium support—*i.e.*, the precise information an insurer needs to ensure that the dialysis provider is not billing at a level above the reimbursement cap.

The district court analogized the disclosure requirement here to the one at issue in *Americans for Prosperity*, 1-PER-54, but the comparison is inapt. There, the government sought to require disclosure of the names, addresses, and contribution amounts of "a charity's top donors," *Americans for Prosperity*, 594 U.S. at 612-13, which had allegedly led to "threats and harassment in the past," *id.* at 604. And the evidence showed that that "sensitive donor information" was

"relevant" to the State's law-enforcement efforts in only "a small number of cases." *Id.* at 614. Here, in contrast, AB 290 requires the disclosure to health insurers only of enrollees' names and the fact that they are receiving third-party premium support—nothing more. And as plaintiffs themselves acknowledge, without such information, insurers will likely find it difficult or impossible to confirm that providers are complying with the reimbursement cap, which is an important component of the Legislature's scheme for regulating the dialysis industry.

CONCLUSION

The judgment of the district court should be affirmed in part and reversed in part, and the case should be remanded for entry of judgment in favor of the State Defendants with respect to all provisions of AB 290 other than the anti-steering provisions.

Dated: December 2, 2024

Respectfully submitted,

/s/Joshua Patashnik

ROB BONTA
Attorney General of California
MICHAEL J. MONGAN
Solicitor General
HELEN H. HONG
Principal Deputy Solicitor General
THOMAS S. PATTERSON
Senior Assistant Attorney General
JOSHUA PATASHNIK
Deputy Solicitor General
R. MATTHEW WISE
MARK R. BECKINGTON
Supervising Deputy Attorneys General
LISA J. PLANK
S. CLINTON WOODS
Deputy Attorneys General
CALIFORNIA DEPARTMENT OF JUSTICE
600 West Broadway, Suite 1800
San Diego, CA 92101
(619) 738-9628
josh.patashnik@doj.ca.gov
Attorneys for Defendants

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 17. Statement of Related Cases Pursuant to Circuit Rule 28-2.6

Instructions for this form: http://www.ca9.uscourts.gov/forms/form17instructions.pdf

9th Cir. Case Number(s) 24-3654, 24-3655, 24-3700

The undersigned attorney or self-represented party states the following:

- (•) I am unaware of any related cases currently pending in this court.
- ( ) I am unaware of any related cases currently pending in this court other than the case(s) identified in the initial brief(s) filed by the other party or parties.
- ( ) I am aware of one or more related cases currently pending in this court. The case number and name of each related case and its relationship to this case are:

Signature s/ Joshua Patashnik **Date** 12/2/24

*(use "*s/[typed name]*" to sign electronically-filed documents)*

UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

Form 8. Certificate of Compliance for Briefs

Instructions for this form: http://www.ca9.uscourts.gov/forms/form08instructions.pdf

9th Cir. Case Number(s) 24-3654, 24-3655, 24-3700

I am the attorney or self-represented party.

This brief contains 14,612 **words,** including 0 words manually counted in any visual images, and excluding the items exempted by FRAP 32(f). The brief's type size and typeface comply with FRAP 32(a)(5) and (6).

I certify that this brief *(select only one)*:

- ○ complies with the word limit of Cir. R. 32-1.
- ◉ is a **cross-appeal** brief and complies with the word limit of Cir. R. 28.1-1.
- ○ is an **amicus** brief and complies with the word limit of FRAP 29(a)(5), Cir. R. 29-2(c)(2), or Cir. R. 29-2(c)(3).
- ○ is for a **death penalty** case and complies with the word limit of Cir. R. 32-4.
- ○ complies with the longer length limit permitted by Cir. R. 32-2(b) because *(select only one)*:
  - ☐ it is a joint brief submitted by separately represented parties.
  - ☐ a party or parties are filing a single brief in response to multiple briefs.
  - ☐ a party or parties are filing a single brief in response to a longer joint brief.
- ○ complies with the length limit designated by court order dated ____.
- ○ is accompanied by a motion to file a longer brief pursuant to Cir. R. 32-2(a).

Signature s/ Joshua Patashnik **Date** 12/2/24
*(use "*s/[typed name]*" to sign electronically-filed documents)*

CERTIFICATE OF SERVICE

I certify that on December 2, 2024, I electronically filed the foregoing document with the Clerk of the Court of the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF system. I certify that all other participants in this case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: December 2, 2024 */s Joshua Patashnik*