

No. 18-35892

**IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT**

E.S., by and through her parents, R.S. and J.S., and JODI STERNOFF, both on their own behalf, and on behalf of all similarly situated individuals,

Plaintiffs-Appellants,

v.

REGENCE BLUESHIELD; and CAMBIA HEALTH SOLUTIONS, INC.,
f/k/a THE REGENCE GROUP,

Defendants-Appellees.

On Appeal from the United States District Court
for the Western District of Washington

**MOTION FOR LEAVE TO FILE BRIEF OF DISABILITY RIGHTS
EDUCATION AND DEFENSE FUND, ET AL., AS *AMICI CURIAE*
IN SUPPORT OF PLAINTIFFS-APPELLANTS**

Pursuant to Federal Rules of Appellate Procedure 29(a)(3), *amici curiae* respectfully request leave of this court to file the attached brief in support of Plaintiffs-Appellants. *Amici* are the Disability Rights Education and Defense Fund; the National Association of the Deaf; the Bazelon Center for Mental Health Law; the Hearing Loss Association of America; the Hearing Loss Association, Oregon State Association; the Washington State Communication Access Project; the Oregon Communication Access Project; and the California Communication Access Project.

Amici collectively share the mission of advancing the equality of people with hearing disabilities and removing discriminatory barriers to coverage of the health care services and devices that they need to fully participate in American society.

The **Disability Rights Education and Defense Fund (“DREDF”)** is a national law and policy center that protects and advances the civil and human rights of people with disabilities through legal advocacy, training, education, and development of legislation and public policy. DREDF played a key role in the development and passage of the Americans with Disabilities Act and has significant experience in health care law and policy. DREDF is committed to promoting accessible and equally effective health care and eliminating persistent health disparities, which threaten to undermine the goals of nondiscrimination law.

The **National Association of the Deaf (“NAD”)**, founded in 1880, is the oldest civil rights organization in the United States and is the nation’s premier organization of, by, and for 48 million deaf and hard of hearing individuals. NAD’s mission is to preserve and promote the civil, human, and linguistic rights of deaf and hard of hearing individuals by achieving systemic changes in all aspects of society, including full access to programs and services such as insurance coverage for hearing-related medical needs. This court’s findings of disability discrimination under the Affordable Care Act will affect our members nationwide.

The **Bazon Center for Mental Health Law** is a national nonprofit legal advocacy organization advancing the rights of people with mental disabilities in all

areas of life, including health care, community living, employment, education, housing, family rights, and other areas. The Center was deeply involved in securing passage of the Affordable Care Act, including Section 1557, and has also litigated cases challenging disability-based discrimination in insurance benefits.

The **Hearing Loss Association of America (“HLAA”)**, founded in 1979, opens the world of communication to people with hearing loss through information, education, support, and advocacy. HLAA holds an annual educational convention and trade show; publishes a bimonthly magazine, *Hearing Life*; produces the *Walk4Hearing*; and advocates for people with hearing loss. HLAA also has an extensive network of chapters and state organizations.

The **Hearing Loss Association, Oregon State Association’s** primary purposes are to encourage identification of persons of all ages who have hearing loss; provide education for people with hearing loss, their families, their friends, and the general public on the nature of hearing loss, its ramifications, and how best to manage this condition; develop and support programs aimed at alleviating the problems related to hearing loss; and engage in free and open communication with all concerned so as to find a common basis of fellowship and understanding.

The **Washington State Communication Access Project (“Wash-CAP”)** is a non-profit organization dedicated to enabling persons who are hard of hearing to fully enjoy public venues and share the same experience as the hearing public. WASH-CAP accomplishes these goals by working with sports, entertainment,

cultural, governmental, and other venues, and, when necessary, compelling these venues to provide equal access. When people cannot access hearing loss treatment, hearing aids, and captions, we face an equity issue.

The **Oregon Communication Access Project (“OR-CAP”)** is a non-profit corporation whose purpose is to eliminate or reduce communication barriers that individuals with hearing loss face in Oregon’s public places. OR-CAP’s objective is to enable those with hearing loss, particularly those who do not use sign language as their principal means of communication, to enjoy public places and participate in public life as fully as those without hearing loss, to the extent such full participation is technologically and economically possible.

The **California Communication Access Project (“C-CAP”)** is a California public benefit corporation that aims to enrich the lives of its members and similarly situated persons by ensuring the availability of auxiliary aids and services that make aurally delivered communication in public spaces accessible to persons with hearing loss. C-CAP advocates via communication, education, cooperation, and, if necessary, litigation.

Amici submit this brief in support of Plaintiffs-Appellants in order to ensure a proper understanding and application of disability nondiscrimination legal principles relevant to this case. Specifically, this brief focuses on the meaning of the U.S. Supreme Court’s decision in *Alexander v. Choate*, 469 U.S. 287 (1985), a case that the district court below relied on in dismissing the Plaintiffs-Appellants

discrimination claims. The brief rebuts the district court's inaccurate and harmful misreading of *Choate* and it presents proper framework under which the court should analyze Section 1557 disability discrimination claims. Through this brief, *amici* aim to ensure that the civil rights of people with hearing loss are accurately understood and fully recognized.

Counsel for Plaintiffs-Appellants consented to the filing of this brief. Counsel for Defendants-Appellees have not provided consent to the filing. Accordingly, *amici* respectfully request leave to file the attached Brief of Disability Rights Education and Defense Fund, et al., As *Amici Curiae* in Support of Plaintiffs-Appellants.

Dated: January 30, 2019

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CERTIFICATE OF SERVICE

I hereby certify on January 30, 2019, I electronically filed this motion with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF System. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rules of Appellate Procedure 26.1 and 29(a)(4)(A), *amici* certify that they have no parent corporations or any publicly held corporations owning 10% or more of their stock.

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INTEREST OF *AMICI CURIAE*¹

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While each *amicus* has its own interests, together they share the objective of advancing the equality of people with hearing disabilities and removing discriminatory barriers to coverage of the health care services and devices that they need to fully participate in American society. *Amici* work on behalf of people with hearing loss in Washington, Oregon, California, and throughout the country to remove barriers to equality through various advocacy techniques, including litigation, public policy development, education, and community engagement. *Amici* submit this brief in support of Plaintiffs-Appellants in order to ensure a proper understanding and application of disability nondiscrimination legal principles relevant to this case.

¹ No counsel for a party has authored this brief in whole or in part, and no person besides *amici* and their counsel contributed money that was intended to fund preparing or submitting this brief. *See* Fed. R. App. P. 29(a)(4).

INTRODUCTION

In *E.S. v. Regence Blueshield*, the U.S. District Court for the Western District of Washington erroneously held that Section 1557 of the Affordable Care Act (“ACA”), which prohibits disability discrimination in health care, does not reach claims that would result in an expansion of the “content” or “scope” of benefits covered by a health plan. *See* No. C17-01609RAJ, 2018 U.S. Dist. LEXIS 163287, at *6–7 (W.D. Wash. Sept. 24, 2018). The district court also mistakenly concluded that *Choate* permits condition-based benefit exclusions—even those targeted at people with disabilities—so long as they do not distinguish between disabled and non-disabled insureds. *Id.* at *7. As Plaintiffs-Appellants argue, this interpretation undermines the purposes of the ACA and Section 1557. Because Section 1557 incorporates the “grounds” and “enforcement mechanisms” of Section 504 of the Rehabilitation Act, *see* 42 U.S.C. § 18116(a), the court below relied on the U.S. Supreme Court’s decision in *Alexander v. Choate*, 469 U.S. 287 (1985), to conclude that Section 504, and therefore Section 1557, does not reach claims of discrimination that challenge the discriminatory “content” of a benefit, even if the challenged policy targets a particular class of disabled insureds. *See E.S.*, 2018 U.S. Dist. LEXIS 163287, at *6–7. Reliance on *Choate* to reject the claim in this case is unfounded. This brief challenges the district court’s inaccurate and harmful misreading of *Choate* and presents the proper framework under which the court should analyze discriminatory health benefit designs under the ACA.

As a key component of the ACA’s comprehensive reforms to the American health insurance market, Section 1557 prohibits discrimination on the basis of disability in “any health program or activity, any part of which is receiving Federal financial assistance.” 42 U.S.C. § 18116(a). Implementing regulations from the U.S. Department of Health and Human Services (“HHS”) define discrimination to include discriminatory health plan “benefit designs.” 45 C.F.R. § 92.207(b)(2). Plans that, for example, “cover bariatric surgery in adults but exclude such coverage for adults with particular developmental disabilities;” “place[e] most or all drugs that treat a specific condition on the highest cost tiers;” or “exclude bone marrow transplants regardless of medical necessity” would run afoul of Section 1557, HHS guidance explains.²

Despite clear legislative and regulatory definition of “discriminatory benefit designs,” the district court below erroneously relied on the *Choate* decision to limit the discrimination actionable under Section 1557. *See E.S.*, 2018 U.S. Dist. LEXIS 163287, at *6–7. First, as Plaintiffs-Appellants argue, the incorporation of all of Section 504’s substantive law, including the *Choate* precedent, is legally

² HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822 (Feb. 17, 2015); HHS CMS CCIIO, *QHP Master Review Tools for 2015, Non-Discrimination in Benefit Design* (2015), available at http://insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_QHP_Standards.pdf.

questionable.³ However, even if Section 1557 did incorporate Section 504’s substance, the district court failed to properly apply the analysis set forth in *Choate*, both legally and factually.

First, the *Choate* Court was careful to examine the underlying statute—there, the Medicaid Act—to determine if the challenged policy was inconsistent with its purposes. 469 U.S. at 295–301. Following *Choate*’s analysis, the lower court failed to properly consider Regence’s hearing loss exclusion in reference to the expansive purposes of the ACA. There can be no doubt that the ACA and Section 1557 are applicable to claims of discriminatory benefit design, even when they serve to modify the content of the health benefit.⁴

Second, the *Choate* Court did not broadly foreclose all Section 504 claims based on the “content” of health benefit designs. In ruling against the plaintiffs in *Choate*, the Court was careful to distinguish the benefit in question—durational

³ Plaintiffs-Appellants argue that, in referencing Section 504’s “grounds” and “enforcement mechanisms,” Congress only intended to incorporate Section 504’s definition of protected class and enforcement procedures. As the Supreme Court has held, a statute’s incorporation of another statute’s enforcement mechanisms does not necessarily mean its substance is incorporated. *See CONRAIL v. Darrone*, 465 U.S. 624 (1984) (cited by *Choate*, 469 U.S. at 295) (holding that Section 504’s incorporation of the “remedies, procedures, and rights” set forth in Title VI of the Civil Rights Act of 1964 did not mean that Section 504 incorporated Title VI’s substantive limitations on actionable discrimination). As such, *Choate* is arguably not binding on Section 1557 interpretation.

⁴ *See, e.g.*, 42 U.S.C. § 18031(c)(1)(A) (qualified health plans must not employ “benefit designs that have the effect of discouraging the enrollment [of] individuals with significant health needs.”).

limits on hospitalization—from facial distinctions based on a disabling condition and distinctions that have a disparate impact on people with certain disabilities. *Id.* at 302 (policies that “apply to only particular handicapped conditions” or those that prevent a condition “occurring with greater frequency among [the handicapped]” from being “effectively treated, at least in part,” could constitute discrimination). The latter claims remain actionable under Section 504. *Id.*

Here, Regence’s hearing loss exclusion both facially targets a specific disabling condition and has a disparate impact on people with hearing impairments. First, Regence’s policy uses a physical condition—hearing loss—as a proxy for a disability⁵ and is thus readily distinguishable from the facially neutral rule at issue in *Choate*. See *E.S.*, 2018 U.S. Dist. LEXIS 163287, at *2; *Choate*, 460 U.S. at 302. Further, the disproportionate effect of Regence’s exclusion is exactly the type of claim that the *Choate* Court contemplated as “within the bounds” of actionable disparate impact. See 460 U.S. at 301–02. The hearing loss exclusion denies health treatments for a condition “occurring with greater frequency” among insureds with hearing disabilities. The inability to hear can affect every aspect of daily life—

⁵ It is specious to argue that Regence’s policy is directed at both disabled and non-disabled insureds. It is obvious that the exclusion’s purpose was to eliminate coverage for hearing aids and other services particular to people with hearing impairments. If the court were to hold otherwise, any insurer could hide behind overly-broad exclusions to claim the policy is neutral. For example, treatment of urinary tract infections (“UTIs”) could be excluded because there could be both men and women insureds affected by the exclusion, even though it is clear that women are far more likely to require treatment for UTIs.

education, work, recreation, civic engagement, and parenting. Without the health services and devices they need to improve their hearing, equal access to the world is denied. Under *Choate* and its progeny, Regence’s exclusion cannot stand.

ARGUMENT

I. THE DISTRICT COURT INCORRECTLY RELIED ON A RESTRICTIVE INTERPRETATION OF *ALEXANDER V. CHOATE* TO DENY PLAINTIFFS-APPELLANTS SECTION 1557 CLAIM

A. *Choate* Held That People with Disabilities Must Have “Meaningful Access” to Health Benefits Under Section 504

In *Alexander v. Choate*, the Supreme Court evaluated whether a proposed reduction in the number of annual inpatient hospital days covered by the Tennessee Medicaid program violated Section 504 of the Rehabilitation Act. 469 U.S. at 289. The plaintiffs, a class of Medicaid recipients, argued that the proposed 14-day limitation on hospitalization—and *any* annual limitation on inpatient days, for that matter—would have a disproportionate effect on Medicaid recipients with disabilities. *Id.* at 290.

After reviewing the statute, regulations, and legislative history of Section 504, the Court held that the statute’s objectives would be “difficult if not impossible to reach” were it construed to not permit claims of disparate impact. *Id.* at 296–99. It reasoned that, in enacting Section 504, Congress intended to reach not only discrimination that was the result of “invidious animus,” but also of “thoughtlessness,” “indifference,” and “benign neglect.” *Id.* at 295–96. However, recognizing the desire to keep Section 504 within manageable administrative

bounds, the Court rejected the disparate impact claim before it. *Id.* at 298–300, 308. In reaching this holding, the Court did not make a broad pronouncement that any claim of discrimination based on the “content” of a benefit was outside the bounds of Section 504. Rather, the Court carefully reviewed the structure and purpose of the underlying Medicaid statute, the evidence of alleged discrimination, and the possible remedies; and it concluded that the plaintiffs’ claim would create a “virtually unworkable requirement” that would fundamentally alter the Medicaid program.

The Court employed a “meaningful access” standard to evaluate the disparate impact claim. *Id.* at 301. It explained: “The benefit itself, of course, cannot be defined in a way that effectively denies otherwise qualified handicapped individuals the meaningful access to which they are entitled; to assure meaningful access, reasonable accommodations in the grantee’s program or benefit may have to be made.” *Id.* The Court did not condone disability-explicit exclusions or policies that have a clear disparate impact on a class of disabled beneficiaries. *See id.* at 301–02.

Applying this standard to the facts of *Choate*, the Court first found that the 14-day policy, designed without reference to a disability or the conditions or benefits uniquely associated with a disability, was “neutral on its face.” *Id.* The Court distinguished the hospitalization limit from policies that facially target disabling conditions: “the durational limitation *does not apply to only particular handicapped conditions* and takes effect regardless of the particular cause of hospitalizations,” it explained. *Id.* at 302 n.22 (emphasis added).

Second, the Court found that the 14-day policy did not give rise to the type of disparate impact cognizable under Section 504 because it did not have a “particular exclusionary effect” on disabled insureds. *Id.* at 302. It explained: “[The policy] does not distinguish between those whose coverage will be reduced and those whose coverage will not on the basis of any test, judgment, or trait that the handicapped as a class are less capable of meeting or less likely of having.” *Id.* Additionally, there was nothing in the record suggesting that disabled insureds could not meaningfully benefit from 14 days of inpatient coverage. *Id.* “The record does not contain any suggestion that *the illnesses uniquely associated with the handicapped or occurring with greater frequency among them cannot be effectively treated*, at least in part, with fewer than 14 days’ coverage,” it explained. *Id.* at 302 n.22 (emphasis added). To the contrary, the Court explained, the evidence showed that the 14-day rule would “fully serve 95% of [disabled Medicaid recipients].” *Id.* at 303.

Finally, the Court rejected the plaintiffs’ alternative contention that “any” annual durational limitation on inpatient coverage would violate Section 504. *Id.* at 306. The Court found that redesigning the inpatient benefit to ensure that disabled recipients were not adversely affected would fundamentally alter the way that the State designed and administered the Medicaid program. *Id.* at 307–08 (explaining that it would be extremely burdensome to “balance the harms and benefits” of this “broad-based distributive decision.”). Because no particular disability was targeted, the Court concluded that the remedy the plaintiffs sought would require States to

prepare “Handicapped Impact Statements” before any action could be taken—a burden, it concluded, Congress could not have intended. *Id.* at 299. Thus, faced with a neutral policy with minimal evidence of a disproportionate effect and an unwieldy administrative burden, the Court declined to find a Section 504 violation in *Choate*. *Id.* at 302, 306.

B. *Choate* Did Not Bar Claims of Discrimination Based on the Content of a Health Benefit

Since the Supreme Court’s decision in 1985, some lower courts—including the district court below—have misinterpreted *Choate* to stand for the proposition that disability nondiscrimination law does not reach the “content” of a health benefit policy, but rather only the ability to “access” the benefit. *See E.S.*, 2018 U.S. Dist. LEXIS 163287, at *6–7; *see also, e.g., Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557 (7th Cir. 1999). These cases categorically conclude that a plan can offer any package of health benefits—no matter how disproportionately its design disadvantages disabled people—so long as that package is equally offered to all beneficiaries. In *E.S.*, the district court justified this access/content distinction by erroneously implying that *Choate* deemed all challenges to content a fundamental program alteration. *See* 2018 U.S. Dist. LEXIS 163287, at *6–7. It also asserted that Congress did not intend to reach the content of health benefits when it enacted the ACA. *See id.* Other courts have justified their broad rejection of content-based claims by citing *Choate*’s explicit denouncement of an “adequate health care”

standard and its administrative burden concerns. *See, e.g., Doe*, 179 F.3d at 563–64. The access/content distinction, however, is not supported by *Choate* or its reasoning.

The Supreme Court did not foreclose content-based discrimination claims in *Choate*, nor did it assert that all content-based remedies would fundamentally alter the nature of a health program. Instead, the Court concluded, based on the evidence at hand, that the remedy the *Choate* plaintiffs sought (evaluating and eliminating all durational limits on the Medicaid inpatient benefit) went beyond the “meaningful access” required by Section 504 because it would impose a unjustified and “unworkable” requirement on Medicaid administrators. 469 U.S. at 302, 308. This factual finding was a far cry from holding that all content-based claims were barred by the fundamental alteration defense.⁶

Additionally, while the *Choate* Court did reject the suggestion that Medicaid must design its plans to provide “adequate health care,” this did not mean that the content of the plan was altogether free of antidiscrimination scrutiny. Leslie Francis & Anita Silvers, *Reading Alexander v. Choate Rightly: Now is the Time*, 6 Laws, no. 17 (2017), at 4. Actually, the Court explicitly adopted a standard that considers the substance of a health benefit: “[t]he benefit . . . cannot be defined in a way that effectively denies [disabled people] *meaningful* access.” *Choate*, 469 U.S. at 301 (emphasis added). The Court did not just say that disabled insureds must have similar

⁶ For further discussion of the fundamental alteration defense and why, under the facts here, there is no fundamental alteration, *see infra* Section IV.

“access” to whatever benefits the plan happens to provide, regardless of the effect on particular disabilities. Rather, such access must be “meaningful.” The term “meaningful” would be superfluous if it did not impose a substantive standard on the type of access that an insured must receive. *Francis & Silvers, supra*, at 4–5.

This reading is also supported by the *Choate* Court’s analysis of the evidence. The Court did not just scrutinize whether the inpatient benefit applied on the same terms to both people with or without disabilities (the pure “access” question); instead, it also considered whether the structure of the benefit policy disproportionately prevented disabled people from receiving a meaningful benefit from the inpatient coverage (a “content” question). *See* 469 U.S. at 290, 302. While the Court found insufficient evidence of a disproportionate burden in the record at hand, its holding did not foreclose the possibility that the content of other health benefit policies could constitute discrimination. *See id.* Actually, the Court explicitly endorsed a disparate impact analysis and gave numerous examples of “content” that could in fact inhibit meaningful access for disabled people. *See id.* at 296–99, 302.

Throughout its analysis, the Court was careful to distinguish the 14-day rule at issue in *Choate* from other types of policies that would rise to discrimination. For example, it suggested that policies that “apply to only particular handicapped conditions;” those that “take[] effect [based on a] particular cause of hospitalization[];” or those that prevent conditions “uniquely associated with the handicapped or occurring with greater frequency among them” from being

“effectively treated, at least in part,” could violate Section 504. *Id.* at 302 n.22. Each of these examples is focused on content—that is, the content of the health benefit, and not just threshold access to such benefit, would need to change in order to correct the discrimination. Thus, by its own terms, *Choate* did not bar content-based discrimination claims.

Finally, if *Choate* were read to create an arbitrary distinction between “content” and “access,” then it would render nondiscrimination protections illusory in the health benefit context. By framing discrimination only as a matter of access, a health insurer could always manipulate their benefit design to elude discrimination law, despite maintaining the same discriminatory effects. As an example, consider cancer benefits. Under the access/content distinction, a health insurer could not deny an individual with cancer enrollment in a qualified health plan or equal access to the treatments, services, and prescription drugs the plan chooses to cover; however, it could exclude from its coverage all cancer-related surgery, chemotherapy, radiation, and post-treatment drugs. For a person with cancer, access to a health plan would be deemed virtually meaningless in the absence of cancer-related coverage. The effect of these condition-based exclusions would be the same as an outright denial of enrollment. The access/content distinction perversely encourages this result. It incentivizes insurers to find roundabout ways to deter people with pre-existing conditions from their plans. This is impermissible under Section 1557. *See* 42 U.S.C. §§ 18116(a), 18031(c)(1)(A); 45 C.F.R. § 92.207(b)(2).

The Supreme Court recognized a similar subterfuge concern in *Choate*. It explained: “Antidiscrimination legislation can obviously be emptied of meaning if every discriminatory policy is ‘collapsed’ into one’s definition of what is the relevant benefit.” 469 U.S. at 301 n.21. The Court cited a passage that explained further:

[O]ne can argue that a rampless library is offering, as a service, "books-in-a-building-without-ramps," and that *that* is available equally to all; similarly, the fox and the stork do have equal access to the benefit of "milk-in-a-long-necked-container" if that is how one chooses to define the benefit.

Brief for the United States as *Amicus Curiae* 29, n.36, *Alexander v. Choate*, 469 U.S. 287 (1985). The point, for purposes here, is that a benefit can always be defined in way to avoid access issues, and thus an interpretation of *Choate* that only permits such “access-based” claims would wholly undermine the purpose of disability nondiscrimination law. Therefore, the access/content distinction is unsupported by both *Choate* and public policy.

C. Ninth Circuit Precedent Does Not Justify Importing an Access/Content Distinction into Section 1557

The U.S. Court of Appeals for the Ninth Circuit has not adopted the access/content distinction in the context of health benefits. Arguably, the closest it came was in *Weyer v. Twentieth Century Fox Film Corporation*, an Americans with Disabilities Act (“ADA”) case involving a long-term disability insurance policy that limited benefits to 24 months for individuals with mental disabilities but imposed no such limitation on individuals with physical disabilities. *See* 198 F.3d 1104, 1107–

08 (9th Cir. 2000). The Ninth Circuit concluded that distinctions between different types of disabilities did not violate the ADA, citing a well-established industry practice of distinguishing between mental and physical disabilities and Congress' lack of explicit language abrogating the practice. *Id.* at 1116–17.

Weyer is not controlling on Section 1557 health benefit design discrimination claims. First, *Weyer* is distinguishable because it involved a long-term disability insurance policy and not a health benefit policy. Generally, long-term disability insurance provides a daily cash benefit intended to replace a beneficiary's employment income upon encountering an illness or injury that prevents work. Long-term disability insurance is *income* insurance, not health insurance. The income and health insurance markets are distinct industries; they are subject to different federal laws, regulated by different entities, and characterized by disparate purposes, market structures, and industry norms.⁷ Section 1557 of the ACA reaches only *health* programs and activities, not other forms of insurance coverage. 42 U.S.C. § 18116(a). Case precedent dictating permissible policies in the distinct context of long-term disability insurance, especially when its reasoning is grounded in industry-specific practices and it predates the ACA, is inapplicable to Section 1557.

⁷ See Timothy Jost, *Implementing Health Reform: Excepted Benefits Final Rule*, HealthAffairs (Sept. 29, 2014), <https://www.healthaffairs.org/doi/10.1377/hblog20140929.041684/full/>.

Second, *Weyer* was decided under the ADA, not Section 504. Where statutory differences between Section 504 and the ADA are pertinent to a particular case, claims under the two statutes may not be treated identically. *See, e.g., Henrietta D. v. Bloomberg*, 331 F.3d 261, 272 (2d Cir. 2003). In enacting Section 1557 of the ACA, Congress specifically referenced the nondiscrimination protections of Section 504 and not the ADA. *See* 42 U.S.C. § 18116(a). Unlike Section 504, the ADA has a safe harbor provision that permits insurers, hospitals, and medical service companies to use legitimate underwriting practices. 42 U.S.C. § 12201(c)(1). In contrast, the ACA specifically took aim at medical underwriting and pre-existing condition exclusions, in an effort to eliminate widespread discrimination in health care. *See* 42 U.S.C. §§ 300gg-1–300gg-4. It would have been inconsistent with the purposes of the ACA to incorporate a safe harbor that would silently exclude the discriminatory health care practices the ACA sought to remedy. Because of this important distinction—pertinent to the case at hand—*Weyer*’s precedent does not apply to Section 1557.

II. REGENCE’S HEARING LOSS EXCLUSION IS FACIAL DISCRIMINATION, AS EXPRESSLY CONTEMPLATED IN *CHOATE*

The Supreme Court’s decision in *Choate* is not a bar to—and actually provides clear support for—Plaintiffs-Appellants’ facial discrimination claim. In *Choate*, the Court held that the 14-day inpatient limitation at issue was “neutral on its face” because it applied to all Medicaid recipients and did not facially target any particular

disability or condition. 469 U.S. at 289. However, the *Choate* Court was careful to distinguish the 14-day limit from other benefit policies that could in fact constitute facial discrimination. Notably, in its discussion of why the record in *Choate* did not support a finding of discrimination, it provided the following distinction: “the durational limitation does not apply to only particular handicapped conditions” *Id.* at 302 n.22. The implication, of course, is that if the policy did apply to “particular handicapped conditions,” then it would violate nondiscrimination law.

The Ninth Circuit has also explicitly recognized that health insurance policies that exclude benefits by reason of a disability constitute facial discrimination. For example, in *Lovell v. Chandler*, the Ninth Circuit held that a State health care policy that excluded people who were aged, blind, or disabled from a new managed care program violated Section 504 and the ADA. 303 F.3d 1039, 1052 (9th Cir. 2002). The State had sought to transition its Medicaid enrollees and State Health Insurance Program (“SHIP”) enrollees from fee-for-service (“FFS”) to a single managed care plan. *Id.* at 1045. However, it categorically excluded people who were blind or disabled from the new managed care plan. *Id.* The State allowed Medicaid enrollees with disabilities to remain in their old FFS plan; however, SHIP enrollees with disabilities would be left without any coverage. *Id.* The Ninth Circuit held that the policy constituted both facial discrimination and a denial of meaningful access to the benefits offered in the proposed plan. *Id.* at 1052–54. The exclusion, on its face,

applied less favorably to people who were blind and disabled, and thus it violated nondiscrimination law. *Id.*

Here, Regence’s hearing loss exclusion constitutes facial discrimination within the meaning of *Choate* and *Lovell*. First, the exclusion is representative of the type of policy expressly contemplated by the *Choate* Court to be facial discrimination. The Regence policy specifically targets a “particular handicapped condition[]”—hearing loss—and excludes virtually all programs and treatment for such condition. *E.S.*, 2018 U.S. Dist. LEXIS 163287, at *2; *see Choate*, 469 U.S. at 302 n.22. The exclusion “appl[ies] to only” a specific disabling condition and is thus readily distinguishable from the facially neutral policy at issue in *Choate*, as recognized by the Court itself. *See* 469 U.S. at 302 n.22. A finding of facial discrimination is therefore not precluded, and actually supported, by *Choate*.

Second, Regence’s hearing loss exclusion constitutes facial discrimination within the meaning of the Ninth Circuit’s post-*Choate* precedent. Like in *Lovell*, the exclusion here facially excludes people with a certain condition from a health benefit. *See* 303 F.3d at 1052. In *Lovell*, the policy targeted people who were blind or disabled; here, the policy targets people with hearing loss, which is a proxy for a disability. *See id.*; *E.S.*, 2018 U.S. Dist. LEXIS 163287, at *2. As Plaintiffs-Appellants detail, proxy discrimination is a recognized form of facial discrimination that occurs when the defendant targets a trait or criteria that is almost exclusively held by people in a protected group. *See Pac. Shores Props. v. City of Newport*

Beach, 730 F.3d 1142, 1160 n.23 (9th Cir. 2013). Here, hearing loss serves as a proxy for hearing disabilities. It would be disingenuous to argue that the exclusion is neutral just because some people who are not disabled also are excluded from coverage of, for example, hearing aids. Every person who needs a hearing aid would easily be considered disabled under the ADA Amendments Act of 2008 (“ADAAA”).⁸ It strains logic to argue that the exclusion was targeted at non-disabled people who, for example, may want a hearing screening. Regence’s exclusion was clearly targeted at benefits that people with hearing impairments rely on. Therefore, the exclusion constitutes facial discrimination within the meaning of *Choate* and *Lovell* or, at the very least, it gives rise to a question of fact of whether the exclusion is actually aimed at people with disabling hearing loss.⁹

III. REGENCE’S HEARING LOSS EXCLUSION CONSTITUTES DISPARATE IMPACT DISCRIMINATION WITHIN THE MEANING OF *CHOATE* AND ITS PROGENY

Choate held that people with disabilities must be provided with “meaningful access” to health benefits under Section 504. 469 U.S. at 301. From its analysis, we know that a meaningful benefit must be defined in relation to the purposes of the statute at issue. *Id.* at 301–04. The purpose of the ACA, unlike the Medicaid Act at

⁸ The ADAAA greatly expanded the definition of “disability,” and it certainly includes all people who use hearing aids and other individuals with a hearing loss that substantially limits their daily life activities. *See* 42 U.S.C. § 12102; 29 U.S.C. § 705(9) (the ADA’s disability definition, as amended by ADAAA, applies to Section 504).

⁹ *See* 81 Fed. Reg. at 31434 (“[D]etermining whether a particular benefit design [is pretext for] discrimination will be a fact-specific inquiry.”).

issue in *Choate*, is to ensure that every American, including people with disabilities, has access to comprehensive, affordable, and nondiscriminatory health care coverage.¹⁰ We also know that the limited evidence presented in *Choate* (indicating that the 14-day rule would fully serve 95% of disabled insureds) did not rise to a lack of a meaningful inpatient benefit. *Id.* at 302–03. Beyond these outer limits and the many examples of potentially discriminatory policies the Court provided, *Choate* left room for lower courts to define “meaningful access.”

In the Ninth Circuit, meaningful access is denied when a policy disproportionately burdens disabled people, so as to effectively reduce their access to services, programs, or activities that are accessible to others. *See Crowder v. Kitagawa*, 81 F.3d 1480, 1484–85 (9th Cir. 1996); *see also Rodde v. Bonta*, 357 F.3d 988, 997–98 (9th Cir. 2004). For example, in *Crowder v. Kitagawa*, the Ninth Circuit evaluated whether Hawaii’s animal quarantine rule, neutral on its face, had a discriminatory effect on visually-impaired people who relied on guide dogs. 81 F.3d at 1481–83. The rule mandated a 120-day quarantine for all carnivorous animals entering the State, in an effort to prevent the spread of rabies. *Id.* The State sequestered all guide dogs under the rule, though it did provide housing accommodations for their disabled owners and permitted the dogs to train with them.

¹⁰ For further discussion of the congressional intent of ACA, *see* Brief of the National Health Law Program, et al., as *Amici Curiae* in Support of Plaintiffs-Appellants, *E.S. v. Regence Blueshield*, No. 18-35892 (9th Cir. filed Oct. 12, 2018).

Id. The Ninth Circuit, citing *Choate*, held that the quarantine rule denied visually-impaired people “meaningful access” to public services. *Id.* at 1484–85. It explained:

Although Hawaii's quarantine requirement applies equally to all persons entering the state with a dog, its enforcement burdens visually-impaired persons in a manner different and greater than it burdens others. Because of the unique dependence upon guide dogs among many of the visually-impaired, Hawaii's quarantine effectively denies these persons . . . meaningful access to state services, programs, and activities while such services, programs, and activities remain open and easily accessible by others.

Id. at 1484. In its analysis, the court emphasized how the rule “effectively preclude[d]” people with visual impairments from using public services and participating in their communities. *Id.* at 1485. For example, without their guide dogs, people were unable to use public transit, enjoy parks, and navigate streets and buildings. *Id.* Notably, the court’s analysis focused on how a policy of one type (the movement of animals into the State) can have a discriminatory effect on the accessibility of *other* services, programs, and activities (e.g., transportation and building accessibility). Additionally, it clearly asserted that a denial of an auxiliary aid upon which a disabled individual relies can be cognizable discrimination; as it explained, “[m]any barriers to full participation of the disabled work their discriminatory effects due to the auxiliary aids upon which the disabled rely, and not due solely to the disabling impairment.”¹¹ *Id.* at 1484 n.1.

¹¹ “For example, stairs do not affect [people with] multiple sclerosis solely by reason of their disease; some [people with] multiple sclerosis, particularly in its early stages, may still be able to walk. The architectural barrier of stairs works its discriminatory

Likewise, in *Rodde v. Bonta*, the Ninth Circuit considered whether a county’s decision to close a medical facility that disproportionately provided services to disabled people constituted a denial of “meaningful access.” 357 F.3d at 997–98. The facility was the only one in the county that provided specialized rehabilitative services primarily (but not exclusively) to disabled people. *Id.* The Ninth Circuit, citing *Choate* and *Crowder*, held that the county’s plan denied meaningful access to health care services. *Id.* It explained:

Eliminating entirely the only hospital of six that focuses on the needs of disabled individuals . . . and that provides services disproportionately required by the disabled and available nowhere else in the County is simply *not* the sort of facially neutral reduction considered in *Alexander*. *Alexander* may allow the County to step down services equally for *all* who rely on it for their health-care needs, but it does not sanction the wholesale elimination of services relied upon disproportionately by the disabled because of their disabilities.

Id. at 997 (emphasis in original). The closure of the facility “would deny certain disabled individuals meaningful access to government-provided services because of their unique needs,” it concluded. *Id.* at 998. Thus, it would constitute disability discrimination within the meaning of *Choate*. *Id.*

Here, Regence’s hearing loss exclusion constitutes a denial of meaningful access within the meaning of *Choate* and its Ninth Circuit progeny. First, *Choate* was clear that meaningful access is defined in relation to the objectives of the statute

effect because other [people with] the disease rely on wheelchairs to move around. In this instance, it is not the disease which renders the disabled incapable of accessing services, it is the reliance on a particular type of auxiliary aid which does so.” *Crowder*, 81 F.3d at 1484 n.1.

at issue, and here, the hearing loss exclusion clearly undermines the purposes of the ACA. *See* 467 U.S. at 301–04. The ACA’s purpose was to improve the quality of and access to health care coverage and, specifically, eliminate discrimination against Americans with preexisting conditions, including in health benefit design. There can be no question that the hearing loss exclusion—which targets the condition of hearing loss and disproportionately prevents people who rely on hearing aids from participating in their communities—undermines these express objectives.

Second, the policy is readily distinguishable from the facts in *Choate*. The Supreme Court was clear to assert that “the record d[id] not contain any suggestion that the illnesses uniquely associated with the handicapped or occurring with greater frequency among them c[ould not] be effectively treated at least in part, with fewer than 14 days’ coverage.” *Id.* at 302 n.22. Here, hearing loss—a condition disproportionately associated with disabled people—can, of course, not be effectively treated when all programs and treatment, except cochlear implant surgery,¹² related to that hearing loss are excluded from Regence’s health insurance coverage. The plain language of *Choate* thus supports Plaintiffs-Appellants’ claim.

¹² Cochlear implants (“CIs”) are not an effective treatment for most people with hearing disabilities and they therefore cannot, on their own, constitute “meaningful access” to hearing loss benefits. CI candidacy is strictly limited to people with severe-to-profound hearing loss and who derive insufficient benefit from hearing aids alone. By a recent measure, only 0.2 percent of adults with hearing loss have CIs. *See* HHS NIDCD, *Quick Statistics About Hearing*, <https://www.nidcd.nih.gov/health/statistics/quick-statistics-hearing> (last visited Jan. 28, 2019).

Finally, Regence’s hearing loss exclusion denies meaningful access within the meaning of Ninth Circuit precedent. *See Crowder*, 81 F.3d at 1484–85; *Rodde*, 357 F.3d at 997. The exclusion—explicitly targeted at hearing loss—imposes a far greater burden on disabled people than non-disabled people. Specifically, Regence’s policy denies people with hearing disabilities the programs, treatments, and auxiliary aids (i.e., hearing aids) that they need to meaningfully benefit from their health coverage and other major life activities. Like in *Crowder*, the policy precludes people with specific disabilities from fully benefitting from education,¹³ employment,¹⁴ and public services, and it inhibits their effective participation in their communities.¹⁵ *See* 81 F.3d at 1485. Just like quarantining a blind individual’s guide dog, Regence’s hearing loss exclusion erects a barrier to full participation in society by blocking access to an auxiliary aid upon which a person with a disability relies.

¹³ Children with hearing loss can have trouble with speech, language, social skills, and learning in school. Am. Speech-Language-Hearing Assoc., *Hearing Aids for Children*, <https://www.asha.org/public/hearing/hearing-aids-for-children/> (last visited Jan. 27, 2018).

¹⁴ Hearing loss correlates significantly with reduced employment and income. David Jung & Neil Bhattachayya, *Association of Hearing Loss with Decreased Employment and Income Among Adults in the United States*, 121 *Annals Otology, Rhinology & Laryngology*, no. 12, 771–75 (2017). The total loss to the economy from hearing loss is well into the billions of dollars, and some of that economic impact can be ameliorated by wider use of hearing aids. Huddle MG, et al., *The Economic Impact of Adult Hearing Loss: A Systematic Review*, 143 *J. Am. Medical Assoc.*, no. 10, 1040–48 (2017).

¹⁵ Hearing loss has also been associated with cognitive declines. Frank R. Lin, et al., *Hearing Loss and Cognitive Decline Among Older Adults*, 173 *J. Am. Medical Assoc.*, no. 4, 293–99 (2013).

See id. at 1484 n.1. Moreover, like in *Rodde*, the hearing loss policy is a “wholesale elimination of services relied upon disproportionately by the disabled because of their disabilities.” *See* 357 F.3d at 997. A health insurer cannot single out a service that people with disabilities disparately rely on “because of their unique needs” and exclude that service from coverage. *See id.* at 998. Like the specialized rehabilitative benefits at issue in *Rodde*, the exclusion of hearing loss benefits denies meaningful access to health services. *See id.* at 997–98. It thus constitutes discrimination on the basis of disability.

IV. ELIMINATION OF REGENCE’S HEARING LOSS EXCLUSION WOULD NOT CONSTITUTE A FUNDAMENTAL ALTERATION

As a defense to a Section 504 claim, the outer limit of actionable disability discrimination is when the modification would constitute an “undue burden” or “fundamental alteration” to the essential nature of the program at issue. *See Choate*, 469 U.S. at 300–01. Undue burden and fundamental alteration are questions of fact, properly decided *after* plaintiffs have obtained relevant evidence through discovery. The Supreme Court’s decision in *Choate* relied on a factual finding that redesigning the State Medicaid program to eliminate any durational hospitalization limit would fundamentally alter the nature of the Medicaid program. *Id.* at 307–08. The Court analyzed the purpose of the Medicaid Act, finding that its objective was not to provide “adequate health care” and thus State Medicaid administrators could not be required to undertake an “unworkable” burden of conducting the in-depth analyses

required to evaluate the impact of every variation of the hospitalization benefit. *Id.* “Before taking any across-the-board action,” the Court explained, such a mandate would require the State to engage in a complex distributive analysis of the effect the policy would have on disabled people as a whole and on people with particular disabilities. *Id.* This heavy administrative burden, the Court concluded, was “beyond the accommodations” required under Section 504. *Id.*

In contrast to the facts in *Choate*, the elimination of Regence’s hearing loss exclusion would not constitute a fundamental alteration to the ACA-regulated insurance program at issue here. First, following *Choate*’s analysis, the purposes of ACA (unlike the Medicaid Act) are to ensure that every American, including disabled people, has access to comprehensive, affordable, and nondiscriminatory health care coverage. Consistent with that purpose, the ACA explicitly regulates the content of private health insurance plans, requiring them to cover essential health benefits and not employ benefit designs that discriminate on the basis of disability or otherwise discourage individuals with significant health needs from enrolling in their plans. *See* 42 U.S.C. §§ 18116(a), 18022, 18031(c)(1)(A); 45 C.F.R. § 92.207(b)(2). Unlike in *Choate*, here, the ACA created a robust administrative regime to evaluate and monitor health benefit designs. Private health plans have a pre-existing legal duty to examine the structure of their health benefits and ensure that such designs do not discriminate on the basis of disability. *See id.* An examination of the discriminatory structure and effects of Regence’s health plan is

thus not only consistent with the purposes of the ACA, but it is already required by the statute and its implementing regulations.

Second, the elimination of Regence’s hearing loss exclusion is a far cry from the heavy administrative burden at issue in *Choate*. In *Choate*, the Supreme Court was wrestling with the unworkable burden of evaluating whether any durational hospitalization limit would disparately impact disabled people. *See* 469 U.S. at 307–08. The benefit at issue in *Choate* was neutral on its face; it did not target a physical trait that is disproportionately held by people with disabilities; and there was little evidence of its disparate impact on disabled insureds. *See id.* at 302. In sharp contrast, Regence’s hearing loss exclusion facially discriminates by using a physical condition as a proxy for a disability, and it has a clear disparate impact on people with hearing disabilities. *See supra* Sections II, III. It would hardly be difficult for Regence to identify and remove such discriminatory policies. It does not require a complex distributive analysis to recognize that a policy that excludes “programs and treatment for hearing loss” disparately impacts people with hearing disabilities.

Finally, a finding that Regence’s hearing loss exclusion discriminates on the basis of disability will not transform every health care policy into a ‘top end gold-level plan.’ As Plaintiffs-Appellants describe in detail, there are limits to a finding of discriminatory benefit design. A health insurer may justify a policy limitation with medical or scientific justification, and it may continue to exclude services on an individualized basis for a lack of medical necessity or as an experimental or

investigational benefit. It may not, however, continue to arbitrarily deny disabled people the medical services and devices they depend on for their daily functioning.

CONCLUSION

The district court gravely misinterpreted *Choate* to impose an unwarranted limit on actionable disability discrimination under Section 1557. Its decision wholly undermines the ACA, which was intended to expand and improve the quality of private health coverage *on a nondiscriminatory basis*. Regence's hearing loss exclusion is a clear example of the type of discriminatory benefit design that Congress intended to eliminate when it enacted the ACA's comprehensive reforms. The *Choate* Court, viewing Regence's exclusion in relation to this clear purpose, would not let the district court's decision stand.

Dated: January 30, 2019

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I certify that pursuant to Federal Rules of Appellate Procedure 29, 32(a)(5), and 32(a)(7), the foregoing *amici curiae* brief is proportionally spaced, has a typeface of 14-point Times New Roman, and contains 6,836 words, excluding those sections identified in Federal Rule of Appellate Procedure 32(f).

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CERTIFICATE OF SERVICE

I hereby certify on January 30, 2019, I electronically filed this brief with the Clerk of the Court for the United States Court of Appeals for the Ninth Circuit by using the appellate CM/ECF System. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

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