No. 19-15074

IN THE UNITED STATES COURT OF APPEALS
FOR THE NINTH CIRCUIT

JOHN DOE ONE, JOHN DOE TWO, JOHN DOE THREE, and JOHN DOE FOUR, on behalf of themselves and all similarly situated individuals,

Plaintiffs-Appellants,

v.

CVS PHARMACY, INC.; CAREMARK L.L.C.; CAREMARK CALIFORNIA SPECIALTY PHARMACY, L.L.C.; NATIONAL RAILROAD PASSENGER CORPORATION d/b/a AMTRAK; LOWE'S COMPANIES, INC.; and TIME WARNER, INC.

Defendants-Appellees.

On Appeal from the United States District Court
for the Northern District of California

BRIEF OF DISABILITY RIGHTS EDUCATION AND DEFENSE FUND, DISABILITY RIGHTS ADVOCATES, DISABILITY RIGHTS CALIFORNIA, DISABILITY RIGHTS LEGAL CENTER, THE NATIONAL HEALTH LAW PROGRAM, AND THE AMERICAN CIVIL LIBERTIES UNION AS *AMICI CURIAE* IN SUPPORT OF NEITHER PARTY

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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.

Dated: July 1, 2019

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Rules

Administrative Materials

Other Authorities

INTEREST OF *AMICI CURIAE*[1]

Amici are the Disability Rights Education and Defense Fund; Disability Rights Advocates; Disability Rights California; Disability Rights Legal Center; the National Health Law Program; and the American Civil Liberties Union. While each *amicus* has its own interests, together they share the objective of advancing the equality of people with disabilities and removing discriminatory barriers to coverage of the health care services and devices that they need to fully participate in U.S. society. *Amici* work on behalf of people with disabilities in 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 neither party in order to ensure a full understanding and application of federal disability nondiscrimination legal principles relevant to this case and the health care context.

[1] All parties consented to the filing of this brief. 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 enacting the Patient Protection and Affordable Care Act ("ACA") in 2010, Congress sought to ensure that all Americans, including Americans with disabilities, have equal and comprehensive access to health insurance coverage. Prior to the ACA, people with disabilities were commonly denied or terminated from health coverage, faced annual and lifetime benefit limits, and could not find affordable coverage.[2] Even if a disabled individual could find health insurance, it would often exclude coverage of pre-existing conditions, fail to offer essential benefits, or otherwise limit benefits based on health status or disability. With the ACA, Congress explicitly outlawed these longstanding discriminatory policies. While Congress did not require a health plan to offer every possible service, it did require it to offer certain minimum features to meet the basic needs of all Americans, without dropping them unexpectedly or denying care because of their race, age, sex, or disability.

Section 1557 of the ACA, prohibiting discrimination in health programs or activities receiving federal financial assistance, is a key component of the ACA's

[2] *See generally, e.g.,* Valarie K. Blake, *An Opening for Civil Rights in Health Insurance After the Affordable Care Act*, 36 B.C. J. L. & Soc. Just. 235 (2016) (describing pre-ACA health insurance discrimination and how the ACA addressed those issues); Sara Rosenbaum et al., *Crossing the Rubicon: The Impact of the Affordable Care Act on the Content of Insurance Coverage for Persons with Disabilities,* 25 Notre Dame J. L. Ethics & Pub. Pol'y 235 (2014) (describing ACA nondiscrimination provisions and focusing on the function of essential health benefits).

comprehensive reforms. *See* 42 U.S.C. § 18116(a). Section 1557 prohibits discrimination on the basis of race, color, national origin, sex, age, and disability. *Id.* It references the "grounds" and "enforcement mechanisms" of other major civil rights statutes; however, because the ACA significantly changed the obligations of covered entities, pre-ACA case law is not necessarily dispositive when determining the scope of Section 1557's protections and remedies.[3] Section 1557 compliments and enforces other ACA provisions, which prohibit pre-existing condition exclusions, mandate coverage of essential health benefits, and prohibit qualified health plan "benefit designs that have the effect of discouraging the enrollment [of] individuals with significant health needs," among other protections. *See* 42 U.S.C. §§ 300gg-3(b)(1), 18022, 18031(c)(1)(A).

The U.S. Department of Health and Human Services ("HHS") issued regulations in 2016 to help implement Section 1557, after receiving considerable public comments through a Request for Information and a Notice of Proposed Rulemaking. The regulations define actionable discrimination to include

[3] Additionally, the fact that Congress refers to the definitions of protected classes and enforcement procedures of the referenced statutes does not mean that all case law is incorporated. A statute's incorporation of another's enforcement mechanisms does not necessarily incorporate its substance. *See CONRAIL v. Darrone*, 465 U.S. 624 (1984) (cited by *Alexander v. Choate*, 469 U.S. 287, 295 (1985)) (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).

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;"[4] "place[e] most or all drugs that treat a specific condition on the highest cost tiers;"[5] or "exclude bone marrow transplants regardless of medical necessity"[6] would run afoul of Section 1557's prohibition on discriminatory benefit design, HHS guidance explains.

Despite clear legislative and regulatory intent to eliminate longstanding, unjust health care practices and specifically outlaw "discriminatory benefit designs," the district court in this case resisted applying Section 1557 to the design of the CVS prescription drug program. *See Doe One v. CVS Pharmacy, Inc.*, 348 F. Supp. 3d 967, 982–86 (N.D. Cal. 2018). Because Section 1557 references Section 504 of the Rehabilitation Act, *see* 42 U.S.C. § 18116(a), the district court below relied on the U.S. Supreme Court decision *Alexander v. Choate*, 469 U.S. 287 (1985),[7] to conclude that Section 504, and therefore Section 1557, cannot operate to "change

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[4] HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,429 (May 18, 2016).

[5] HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822 (Feb. 17, 2015).

[6] CMS CCIIO, *QHP Master Review Tools for 2015, Non-Discrimination in Benefit Design* (2015), http://insurance.ohio.gov/Company/Documents/2015_Non-Discriminatory_Benefit_Design_ QHP_Standards.pdf.

[7] Holding that a proposed reduction in the number of annual inpatient hospital days covered by the Tennessee Medicaid program did not violate Section 504, but recognizing that other disparate impacts on "meaningful access" to health care for people with disabilities may be actionable. *Choate*, 469 U.S. at 289.

the terms of the[] benefit plan . . . simply to meet the reality that [Plaintiffs] have greater medical needs." *Id.* at 985. While *amici curiae* take no position on the specific facts and disposition of this case, reliance on *Choate* to limit claims of "discriminatory benefit design" under Section 1557 is unfounded. This brief challenges the district court's limiting and harmful misreading of *Choate* and presents the proper framework under which Section 1557 discriminatory benefit design claims should be analyzed.

ARGUMENT

I. *ALEXANDER V. CHOATE* DOES NOT LIMIT DISCRIMINATORY BENEFIT DESIGN CLAIMS UNDER SECTION 1557 OF THE ACA

In *Alexander v. Choate*, the U.S. Supreme Court announced the proper standard for analyzing health insurance practices that have a disparate impact on people with disabilities under Section 504 of the Rehabilitation Act. 469 U.S. at 301. The Court, evaluating a Medicaid coverage limitation on hospitalization days, held that disabled beneficiaries cannot be denied "meaningful access" to health care benefits. *Id.* at 301–03. Meaningful access, it explained, must be defined in relation to the underlying purposes of the statute at issue. *See id.* Under the facts of *Choate*, the hospitalization limit was consistent with the objectives of the Medicaid Act, which narrowly sought to provide basic health benefits to low-income residents within a limited administrative framework. *Id.* Thus, the Court denied the Section

504 claim on the facts at hand. *Id.* Critically, however, it left open the possibility of other health care practices violating the nondiscrimination law. *See id.*

Since the Supreme Court's decision in 1985, some lower courts have erroneously cited *Choate* for the proposition that Section 504 and the Americans with Disabilities Act ("ADA") do not reach the discriminatory "content" or "scope" of a health benefit plan. *See, e.g.*, *Doe v. Mutual of Omaha Ins. Co.*, 179 F.3d 557, 560 (7th Cir. 1999). To the extent the district court below has imported this incorrect limitation into Section 1557 of the ACA, it critically misreads the Supreme Court's carefully crafted decision in *Choate* and enshrines the discriminatory health insurance practices the ACA explicitly sought to eliminate. *See CVS Pharmacy*, 348 F. Supp. 3d at 982–86.

A. *Choate* Held That People with Disabilities Must Have "Meaningful Access" to Health Benefits Under Section 504 of the Rehabilitation Act

In *Choate*, the Court evaluated whether a proposed reduction in the number of annual inpatient hospital days covered by the Tennessee Medicaid program violated Section 504. 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 disparate impact on Medicaid recipients with disabilities, who were more likely to require a longer hospital stay than Medicaid recipients without disabilities. *Id.* at 290.

In analyzing the Section 504 claim, the Court recognized the viability of disparate impact theory[8] and employed a "meaningful access" standard to analyze the claim. *Id.* at 296–99, 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." *Id*. The Court did not provide a bright line definition of meaningful access; instead, it considered the following factors: whether the policy undermines the purposes of the underlying statute, as determined by its structure and legislative intent; whether there is a "workable" remedy; and the evidence of discriminatory impact. *Id.* at 302–04.

Applying this standard to the facts of *Choate*, the Court found that the 14-day hospitalization policy did not deny "meaningful access" to the Medicaid benefit under Section 504. *Id.* at 302–04. First, according to the Court, the purpose of the Medicaid Act was to provide "a particular package of health care services." *Id*. at 303. It had a "general aim of assuring that individuals will receive necessary medical care," but the statute's purpose was *not* to provide "adequate health care." *Id*. Second, when considering the limited administrative regime created by the Medicaid Act and the substantial discretion given to the Tennessee Medicaid administrators,

[8] The Court concluded that the objectives of Section 504 would be "difficult if not impossible to reach" were it construed to not permit claims of disparate impact. *Choate*, 469 U.S. 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.

the remedy requested by the plaintiffs (requiring a balancing of all harms and benefits to disabled insureds and preparation of "Handicapped Impact Statements" before any action is taken) would be "virtually unworkable" and fundamentally alter the Medicaid program. *Id.* at 299, 307–08. Third, there was nothing in the record suggesting that disabled insureds could not meaningfully benefit from 14 days of inpatient coverage. *Id.* at 302 "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. To the contrary, the Court noted, the evidence showed that the 14-day rule would "fully serve 95% of [disabled Medicaid recipients]." *Id.* at 303. Therefore, faced with a lack of support from the statute's purposes, an unwieldy administrative burden, and minimal evidence of a disproportionate effect, 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 Health Benefits

Since the *Choate* decision, some lower courts 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.g.*, *Mutual of Omaha*, 179 F.3d at 560. Some of 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. *See Mutual of Omaha*, 179 F.3d at 560. To support this access/content distinction, courts have incorrected cited the *Choate* Court's denouncement of an "adequate health care" or "equal results" standard and its administrative burden concerns. *See id*. at 563–64. The 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 (a balancing of all harms and benefits to disabled insureds) went beyond the "meaningful access" required by the Medicaid Act, was unsupported by legislative intent, and would impose an "unworkable" requirement on the State Medicaid administrators. 469 U.S. at 302, 308. *Choate*'s reasoning was consistent with the Section 504 regulations and decades of case law recognizing a "fundamental alteration" defense to cases brought under Section 504.[9] This factual finding was a far cry from holding that all content-based claims are not actionable.

[9] The outer limit of actionable disability discrimination under the "meaningful access" standard is when the modification would constitute a "fundamental alteration" to the essential nature of the program at issue. *See Choate*, 469 U.S. at 300–01; DOJ Amendment of Regulations Implementing Section 504; Notice of Proposed Rulemaking, 81 Fed. Reg. 6,388, 6,393 (Jan. 19, 2017) (recognizing that

The *Choate* Court's analysis of the evidence also supports this conclusion. The Court did not just scrutinize whether the hospitalization 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 id.* 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 gave numerous examples of "content" that would inhibit meaningful access under the Medicaid Act: 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—in other words, the content of the health benefit, and not just threshold access to such

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the fundamental alteration standard has applied under Section 504 for decades). As a question of fact, the *Choate* plaintiffs' "virtually unworkable" requested relief would have fundamentally altered the State Medicaid program. *Id.* at 307–08. As detailed *infra* Section II.B., the fundamental alteration defense is informed by the ACA's significant expansion of administrative oversight over the content of health benefit plans. This analysis alleviates the *Choate* Court's administrative burden concerns in the context of ACA-regulated health plans.

benefit, would need to change in order to correct the discrimination. Thus, by its own terms, *Choate* did not bar content-based discrimination claims.

Moreover, 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. It could also limit beneficiaries to provider networks that fail to include key oncology specialists, thus avoiding coverage of the expensive treatments they may prescribe. 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 504 and

Section 1557 of the ACA. *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 ways that 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, such a distinction is unsupported by both *Choate* and public policy.

C. Ninth Circuit Precedent Does Not Support Barring Claims of Discrimination Based on the Content of Health Benefits

The U.S. Court of Appeals for the Ninth Circuit has not adopted the access/content distinction in the context of health care benefits. Arguably, the closest it came was in *Weyer v. Twentieth Century Fox Film Corp.*, an 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 discriminatory health benefit design claims.[10] 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, can be regulated by different entities, and are characterized by disparate purposes, market structures, and industry norms.[11] Section 1557 of the ACA reaches only *health* programs and activities, not other forms of insurance

[10] Amici disagree with the decision in *Weyer*. However, for purposes of this case, it is not necessary to reverse *Weyer*, as its precedential value to Section 1557 is limited and its facts are distinguishable.

[11] *See* Timothy Jost, *Implementing Health Reform: Excepted Benefits Final Rule*, HealthAffairs (Sept. 29, 2014), https://www.healthaffairs.org/do/10.1377/hblog20140929.041684/full/.

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.

Second, *Weyer* was decided under the ADA, not Section 504 or Section 1557. 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. "MEANINGFUL ACCESS" TO HEALTH BENEFITS UNDER SECTION 1557 OF THE ACA MUST BE DEFINED IN RELATION TO THE ACA'S SWEEPING REFORMS AND PURPOSES

Following the analysis established in *Choate*, a court must consider the ACA's purposes, possible remedies, and the evidence of discrimination when evaluating whether disabled insureds have "meaningful access" to health benefits under Section 1557.[12] *See* 469 U.S. at 302–04. Given the ACA's express objective to ensure equal and comprehensive access to health care benefits, and Congress and HHS' specific prohibitions on discriminatory benefit designs, there can be no doubt that Section 1557 reaches a wide range of discriminatory health care practices, even when the remedy for that discrimination involves modification to the content or scope of coverage of that health plan. *See, e.g.,* 42 U.S.C. § 18031(c)(1)(A); 45 C.F.R. §92.207(b)(2).

[12] The Sixth Circuit recently rejected the Supreme Court's clear direction in *Choate* that disparate impact discrimination is actionable under Section 504. *See Doe v. Bluecross Blueshield of Tenn*., No. 18-5897, 2019 U.S. App. LEXIS 16785, at *13 (6th Cir. June 4, 2019). In so doing, the court also completely ignored the ACA's purposes and the statutory context for Section 1557, focusing only on Section 504—even though the *Choate* Court was careful to evaluate the challenged policy against the purpose and history of the underlying statute. *See id.* This blatant repudiation of *Choate* and other Section 504 case precedent is contrary to the purposes, letter, and spirit of the law and its long-standing regulations.

A. The ACA's Structure and Purposes Reveal Clear Congressional Intent to Eliminate Longstanding Discriminatory Health Care Practices, Including Discriminatory Benefit Designs

The ACA significantly changed the health insurance industry by expanding access to health coverage and explicitly prohibiting many of the methods historically used by health insurers to minimize costs and risks. Before the ACA, the business model of health care incentivized insurers to avoid covering individuals who had high health needs or who would otherwise be costly to the plan. While there was some federal and state regulation of restrictive coverage policies, insurers still had a large array of discriminatory mechanisms at their disposal to deny enrollment, limit benefits, and impose high premiums and cost-sharing on enrollees with disabilities and pre-existing conditions.[13] The ACA ushered in a new era for health care equity—implementing sweeping reforms to expand coverage; creating protections in enrollment, cost-sharing, and benefit design; and improving the scope and quality of health insurance.

As an integral component of these reforms, Congress mandated comprehensive health benefit coverage and explicitly prohibited discriminatory practices in the *content* of those plans. Prior to the ACA, many states had laws imposing specific coverage mandates for people with particular conditions, such as

[13] *See e.g.,* Blake, *supra* note 2; Rosenbaum et al., *supra* note 2.

requiring coverage of applied behavior analysis therapy for people with autism.[14] However, the ACA created a more robust approach to ensuring that plans offer necessary benefits on a nondiscriminatory basis.

The ACA requires most individual and small group plans to provide comprehensive health coverage, including ten categories of essential health benefits ("EHBs") and the items and services within those categories. 42 U.S.C. § 18022. The ACA directs the HHS Secretary to further define the EHBs and, in doing so, "take into account the health care needs of diverse segments of the population, including women, children, persons with disabilities, and other groups" and "ensure that health benefits established as essential not be subject to denial to individuals against their wishes on the basis of the individuals' age or expected length of life or of the individuals' present or predicted disability, degree of medical dependency, or quality of life," among other considerations. *Id.* § 18022(b)(4). HHS promulgated regulations to allow each state to select an EHB-benchmark plan as a reference point for EHB coverage within each plan. *See* 45 C.F.R. § 156.100. While states have some discretion in selecting a benchmark plan, the "benefit design" of that plan must not "discriminate against individuals because of their age, disability, or expected length of life." 42 U.S.C. § 18022(b)(4)(B); *see also* 45 C.F.R. §§ 156.110(d), 156.125

[14] *See* Kaiser Family Found., *Pre-ACA State Mandated Health Insurance Benefits*, https://www.kff.org/state-category/health-insurance-managed-care/pre-aca-state-mandated-health-insurance-benefits/ (last visited June 20, 2019).

(prohibiting benefit designs that discriminate on the basis of "present or predicted disability, degree of medical dependency, quality of life, or other health conditions"). The EHB framework is designed to ensure access to a broad, comprehensive array of necessary services that effectively meets the health care needs of most individuals.

However, this does not mean that the ACA requires health plans to cover all treatments for all people at a minimal cost to the individual. Rather, the ACA's reforms work to create access to affordable coverage and ensure that the coverage does not deny services on an arbitrary or discriminatory basis. *See* 42 U.S.C. § 300gg-6. Recognizing the need for insurer sustainability, health plans can still vary in terms of cost-sharing, the network of providers offered, and *nondiscriminatory* limits on benefit coverage. For example, plans may continue to use clinically indicated, reasonable medical management techniques when approving or denying services. 45 C.F.R. § 156.125. Insurers may also make use of the annual out-of-pocket limits that shift costs back to the insured, such as uniform copays and deductibles, 42 U.S.C. §§ 300gg-6, 18022(c),[15] and they may offer plans with more or less cost-sharing pursuant to a metal rating system, 42 U.S.C. § 18022(a), (d).[16]

[15] As with any plan management technique, cost-sharing must not discriminate on the basis of disability. This could include financially prohibitive cost-sharing targeted at benefits disproportionately relied upon by disabled beneficiaries.

[16] Qualified health plans are assigned a "Bronze," "Silver, "Gold," or "Platinum" categorization. 42 U.S.C. § 18022(d). The "metal" levels vary in terms of consumer

Further, while insurers cannot base premium rates on health status or disability, they can vary premiums based on coverage of an individual or family, rating area, age (with limitations), participation in employer wellness programs, and tobacco use. 42 U.S.C. §§ 300gg, 300gg–4. Finally, contrary to the mistaken impression of the district court below, Health Maintenance Organizations ("HMOs") and Preferred Provider Organization plans ("PPOs") can still offer "insurance coverage at favorable rates by requiring enrollees to access care from a defined set of in-network physicians." *See CVS Pharmacy,* 348 F. Supp. 3d at 985. The difference, with the ACA, is that those plans can no longer deliberately, thoughtlessly, or simply because of historical precedent fail to include providers such as physiatrists, addiction psychiatrists, or complex wheelchair outfitters as a way of discouraging enrollment of disabled individuals. *See* 45 C.F.R. § 156.130 (detailing the ACA's network adequacy requirements for qualified health plans).

Congress also included Section 1557 in the ACA, which deliberately and logically extended civil rights to the health care context, while the industry was simultaneously reformed by other provisions of the ACA. *See* 42 U.S.C. § 18116(a). Unlike the EHBs, Section 1557 applies to *all* health plans, not just those offered in

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costs, with the Bronze plans offering lower premiums with higher cost-sharing and the higher tiers offering higher premiums with lower cost-sharing. *See id.*

the individual and small group markets. *See id.* Section 1557 echoes the broad language of longstanding civil rights statutes, including Section 504:

> [A]n individual shall not, on the ground prohibited under . . . section 504 of the Rehabilitation Act . . . be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which receives Federal Financial Assistance.

Id.

As part of the ACA's carefully crafted framework, Congress and HHS expressly prohibited insurers from designing plan benefits and employing marketing practices that discourage people with disabilities from enrolling. *See* 42 U.S.C. § 18022(b)(4)(B); 45 C.F.R. §§ 156.110(d), 156.125. Section 1557 is the key to enforcing these reforms. As directed by the statute, HHS determined that Section 1557 prohibits discrimination in how ACA-regulated health plans design and administer benefits: "A covered entity shall not, in providing or administering health-related insurance or other health related coverage . . . have benefit designs that discriminate on the basis of . . . disability." 45 C.F.R. §92.207(b)(2). HHS, including its Office for Civil Rights ("OCR"), has issued regulations and sub-regulatory guidance explaining how to analyze Section 1557 claims.[17] As detailed in

[17] As an agency interpretation of a statute it is charged with enforcing, courts have looked to OCR guidance to determine what constitutes discrimination under Section 1557, finding it persuasive. *See, e.g., Rumble v. Fairview Health Servs.,* No. 14-cv-2037 (SRN/FLN), 2015 U.S. Dist. LEXIS 31591, at *27–28 (D. Minn. Mar. 16, 2015) (citing *Skidmore v. Swift,* 323 U.S. 134, 140 (1944)).

Section II.C *infra*, this guidance includes mechanisms for evaluating plan benefit design for discrimination and many examples of discriminatory policies.

With the ACA, Congress and HHS made clear that people with disabilities can no longer be subjected to discriminatory health insurance practices—whether in access to a health plan or in the structure or scope of that plan's benefits. The ACA explicitly and purposefully created standards for health coverage that included both access and content—establishing a basic structure for comprehensive health coverage through the broad categories of EHBs and prohibiting access- and content-based discrimination through Section 1557. *See* 42 U.S.C. §§ 18022, 18116(a). Following *Choate*'s standard, claims of discrimination in health insurance after the ACA must be examined in the context of the ACA's reforms and expansive purposes. *See* 469 U.S. at 302–04.

B. The ACA Significantly Expanded Administrative Oversight of Health Plans, Alleviating the *Choate* Court's Administrative Burden Concerns

With the ACA, Congress also reformed the remedial framework through which discriminatory practices in health care are addressed. In 1985, the *Choate* Court expressed a legitimate concern about the "virtually unworkable" administrative burden the plaintiffs' requested remedy would place on the Medicaid plan administrators. *See* 469 U.S. at 299, 307–08. This burden, the Court explained, would rise to a fundamental alteration of the State Medicaid program. *See id.*

However, with the ACA, evaluating plan benefit design for disability discrimination is no longer an option for insurers.

The ACA implements a comprehensive, multi-prong approach to monitoring and enforcing its benefit design requirements. In addition to private enforcement mechanisms in Section 1557, all health plans offered on a state's exchange are reviewed by state or federal agencies for compliance with ACA's provisions, including its EHB, cost-sharing, network adequacy, and nondiscrimination requirements. 42 U.S.C. § 18031(c), (d). Plans designs that, for example, have a discriminatory impact on disabled insureds, can now be decertified and removed from the exchange until they come into compliance. *Id.* § 18031(d)(4)(A). Further, all individual and small group health plans offered either on- or off-exchange are reviewed by state agencies for compliance with the EHB provisions, including that the EHB package not be designed in a manner that discriminates against or discourages enrollment of people with disabilities. *See* 45 C.F.R. §§ 156.110, 156.125 (prohibiting discriminatory EHB benefit design); *e.g.*, Cal. Health & Safety Code § 1367.005 (detailing California's EHB oversight mechanisms). The HHS Secretary must also review each state's EHB package, including for whether it covers a diverse population and does not make coverage decisions in ways that discriminate, as well as periodically update it to address any gaps or changes in the evidence base. 42 U.S.C. § 18022(a)(4). If a plan still discriminates after these

review processes, the ACA encourages consumers to file complaints with their state insurance commissioners, HHS OCR, and, if necessary, a court. *See* 42 U.S.C. § 18116(a); 45 C.F.R. § 92.302. These mechanisms require insurers to critically evaluate their benefit design on the front end—or face consequences in court or from federal and/or state regulators.

The exhaustive administrative regime the ACA created for reviewing the content of private health benefit plans simply did not exist at the time *Choate* was decided. Today, asking insurers to review their plans for compliance with nondiscrimination law is no longer the "unworkable" burden contemplated in *Choate*. Instead, the ACA legally requires it. Plans should already be implementing mechanisms for ensuring ACA compliance. If they are not, they will face decertification, HHS OCR complaints, and judicial actions under Section 1557. *See, e.g.*, 42 U.S.C. §§ 18022(a)(4), 18031(c), (d); 45 C.F.R. § 92.302.

C. HHS Provided Extensive Guidance on How to Evaluate Evidence of Discriminatory Benefit Design Under Section 1557

Evaluating whether a plan benefit design constitutes disability discrimination is also no longer a daunting or amorphous burden for health plans or for courts. In implementing the ACA, HHS released extensive guidance on how to identify benefit designs that would contravene the ACA's nondiscrimination protections, including Section 1557. *See, e.g.*, HHS Nondiscrimination in Health Programs and Activities; Final Rule, 81 Fed. Reg. 31,376, 31,377 (May 18, 2016) (hereinafter "Section 1557

Final Rule"); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,822 (Feb. 17, 2015) (hereinafter "2016 NBPP"); CMS CCIIO, Final 2016 Letter to Issuers in the Federally-Facilitated Marketplace 37–38 (Feb. 20, 2015), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/2016-letter-to-issuers-2-20-2015-r.pdf (hereinafter "2016 Letter to Issuers"); CMS CCIIO, Final 2017 Letter to Issuers in the Federally-Facilitated Marketplace 48 (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-2017-Letter-to-Issuers-2-29-16.pdf (hereinafter "2017 Letter to Issuers"); CMS CCIIO, *QHP Master Review Tools for 2015.*

While a fact-based inquiry, HHS developed three primary methodologies for identifying discriminatory practices: (1) an analysis of discriminatory intent; (2) an outlier analysis of cost-sharing and other plan elements; and (3) an analysis of how treatments for select medical conditions align with clinical guidelines and the standard of care. *See id.* A court analyzing a claim of discrimination should rely on these methodologies when evaluating plans for discriminatory benefit designs.

1. Discriminatory Intent Analysis

First, a health plan should be evaluated for intentional discrimination. Section 1557 Final Rule, 81 Fed. Reg. at 31,429–33. HHS describes a series of questions through which discriminatory intent in plan benefit design may be discerned:

- Did the entity use a neutral rule or principle?

- Was the reason for the coverage decision a pretext for discrimination?
- Is coverage for the same or a similar service/treatment available to individuals outside the protected class or those with different health conditions?
- What are the reasons for any differences in coverage?

Id. HHS noted: "we do not affirmatively require covered entities to cover any particular treatment, as long as the basis for exclusion is evidence-based and nondiscriminatory." *Id.* at 31,433–34.

Determining whether a benefit exclusion, cost-sharing structure, or other design feature is a pretext for discrimination is a fact-based inquiry. *See id.* Discriminatory intent may be manifest, such as with coverage exclusions for gender affirming care, or it could be revealed by whistle-blowers or through discovery. *See id.* However, recognizing that Section 1557 captures more than intentional discrimination, HHS also developed two additional methodologies to identify benefit policies with an unintentional, yet in function discriminatory, effect on disabled insureds.

2. Outlier Analysis

Moving further into benefit content, a health plan's coverage elements and cost-sharing structure should be evaluated in relation to other plans. 2016 Letter to Issues, at 40 (cited by Section 1557 Final Rule and reaffirmed in subsequent Letters

to Issuers). HHS describes a benefit design "outlier" analysis and provides a toolkit for states to conduct their own analyses. *Id.* For example, HHS reviews prescription drug formularies for "outliers based on an unusually large number of drugs subject to prior authorization and/or step therapy requirements in a particular USP category and class." *Id.* HHS also examines plans' cost-sharing structures, comparing them to other plans and identifying the outliers with respect to specific benefits. Section 1557 Final Rule, 81 Fed. Reg. at 31,434; 2016 Letter to Issuers, at 38.

HHS OCR has recognized that placing all HIV/AIDS medications in the highest cost-sharing tier would violate Section 1557. *See* Section 1557 Final Rule, 81 Fed. Reg. at 31,434, n. 258; 2016 NBPP, 80 Fed. Reg. at 10,822. In 2014, the National Health Law Program ("NHeLP") and the AIDS Institute filed an HHS OCR complaint to challenge the practice of four private health insurers in Florida who placed every commonly prescribed HIV/AIDS medication, including generic drugs, into the highest cost-sharing tiers.[18] The analysis found that other health insurers had varied tiering or placed HIV drugs on more affordable tiers. HHS agreed that placing all drugs used to treat a certain medical condition in the highest cost-sharing tiers is a discriminatory benefit design prohibited by the ACA. Section 1557 Final Rule, 81

[18] *See* NHeLP & The AIDS Institute, *Administrative Complaint RE: Discriminatory Pharmacy Benefits Design in Select Qualified Health Plans Offered in Florida* (May 28, 2014), https://healthlaw.org/resource/nhelp-and-the-aids-institute-complaint-to-hhs-re-hiv-aids-discrimination-by-fl/.

Fed. Reg. at 31,434, n. 258; 2016 NBPP, 80 Fed. Reg. at 10,822. Subsequently, a pharmaceutical trade industry association found similar problems with medications needed to treat multiple sclerosis and cancer, concluding that there is a "lack of adequate formulary scrutiny on the part of state and federal regulators" and positing that "[this] is exactly the type of practice the ACA was designed to prevent."[19]

The key advantage of an outlier analysis is that it provides an apples-to-apples comparison across benefit plans. It serves to quickly and efficiently identify some discriminatory benefit structures that, outside industry norms, exclude or limit costly benefits that disabled beneficiaries disproportionately rely on. However, an outlier analysis has a significant limitation: it fails to detect unlawful practices that are widespread or historically embedded. As HHS noted, "the mere fact that a benefit design is similar to other benefit designs offered in a market does not establish that the benefit design is non-discriminatory." 2017 Letter to Issuers, at 47.

3. Standard of Care Analysis

Finally, health plan benefit designs should be evaluated for how they align with clinical guidelines and the standard of care. 2016 Letter to Issuers, at 41. HHS explains that it reviews treatments "recommended by nationally-recognized clinical

[19] PhRMA, *Coverage Without Access: An Analysis of Exchange Plan Benefits for Certain Medicines*, http://www.phrma.org/affordable-care-act/coverage-without-access-an-analysis-of-exchange-plan-benefits-for-certain-medicines#sthash.o0bB3Xh0.pdf (last visited June 28, 2019).

guidelines" for select medical conditions and then "ensure[s] that issuers are offering a sufficient number and type of drugs needed to effectively treat these conditions and, on some first line drugs, are not restricting access through lack of coverage and inappropriate use of utilization management techniques." *Id.* "Issuers are expected to impose limitations and exclusions based on clinical guidelines and medical evidence," HHS makes clear. *Id.* at 38; *see also* 2016 NBPP, 80 Fed. Reg. at 10,822.

HIV advocates have raised the issue of arbitrary coverage exclusions in the context of single-tablet therapy for HIV.[20] Single-tablet therapy is a combination of antiretroviral drugs in one tablet and has become the standard of care in HIV treatment because it supports adherence and helps prevent drug resistance. HHS concluded that plans that cover some treatments, but fail to cover the standard of care for HIV treatment, are discriminatory.[21] This conclusion underscores how plans can meet the minimum coverage standard for EHBs, yet still run afoul of nondiscrimination protections. *See also* 45 C.F.R. §§ 156.125 (an issuer does not provide EHB if its benefit design discriminates), 156.122(a)(1) (requiring coverage of one drug per USP class/category or the EHB-benchmark, whichever is greater).

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[20] *See, e.g.,* HIV Health Care Access Working Group, *Comments on CMS Notice of Payment and Benefit Parameters for 2016* (Dec. 22, 2014) at 2, https://www.regulations.gov/document?D=CMS-2014-0152-0144.

[21] HHS Panel on Antiretroviral Guidelines for Adults and Adolescents, *Guidelines for the Use of Antiretroviral Agents Adults and Adolescents with HIV* (Oct. 25, 2018), https://aidsinfo.nih.gov/contentfiles/lvguidelines/adultandadolescentgl.pdf.

The standard of care analysis serves to identify benefit structures that, contrary to the purposes of the ACA, exclude or limit the essential medical treatments that people with disabilities or chronic conditions rely on to live and function in their communities. For example, the wholesale exclusion or imposition of exorbitant cost-sharing burdens (e.g., 100% co-insurance)[22] on the coverage of medically necessary wheelchairs or similar mobility devices, clearly violates the standard of care for several medical conditions, and it has a devastating impact on the people who need these devices. Such targeted, disproportionate harms to the health of an identifiable group are precisely what Congress sought to eliminate with the ACA.

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Using these methodologies, a court can readily examine whether a health plan benefit design denies "meaningful access" to benefits within the meaning of Section 1557. Any exclusion, limitation, or other benefit policy that serves as a barrier to medically necessary treatment for individuals with disabilities must be closely examined for discrimination. Following *Choate*'s emphasis on legislative intent, this analysis must take into consideration the changes the ACA created in health insurance programs, the examples of discrimination that have been directly

[22] With a 100% co-insurance rate, which is common among Bronze health plans in California, the consumer would pay 100% of costs up to the out-of-pocket maximum (in 2019, up to $7,900 for an individual and $15,800 for a family).

addressed by the ACA, and the guidance provided in the text of the statute, its regulations, and sub-regulatory guidance offered by HHS.

CONCLUSION

Congress carefully crafted the ACA to provide broad access to health care coverage and protect against discrimination in the content of that coverage. Section 1557 explicitly prohibits discrimination, complimenting and enforcing the rights found throughout the ACA to access meaningful health care coverage regardless of race, sex, age, health status, and disability. Thus, as courts evaluate claims of Section 1557 discrimination, they must look to the expansive purposes of the ACA. Without recognizing the application of Section 504 to benefit design, the array of protections included in the ACA and the new approaches it prescribes to eliminate discrimination in health insurance would be rendered null.

Dated: July 1, 2019

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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 6,989 words, excluding those sections identified in Federal Rule of Appellate Procedure 32(f).

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CERTIFICATE OF SERVICE

I hereby certify on July 1, 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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